Instructions

Australian Government
Department of Human Services

centrelink

# Verification of medical condition(s)

**This information will help the Australian Government Department of Human Services to:**

- confirm details of the main medical conditions affecting the person's capacity to work
- assess how these conditions affect the person's capacity to work or take part in other activities
- identify suitable interventions and assistance to help the person into work or stay in a job.

**This form is not a medical certificate. It is not used to determine whether a person can be granted an exemption from their Mutual Obligation Requirements or paid Sickness Allowance.** Mutual Obligation Requirements means Activity Test or participation requirements under the *Social Security Act 1991*.

## Instructions for the customer

**1 Contact your doctor and make an appointment to have this form completed.**

Make sure the doctor and their receptionist know that you will need this form completed, as a long consultation may be required. If your doctor does not bulk bill, your consultation fee may be more than usual because of the extra time taken to complete the form.

**2 Attend the appointment with your doctor.**

**3 When your doctor has completed this form, return it by post to:**

**Department of Human Services**
**Disability Services**
**Reply Paid 7806**
**CANBERRA BC ACT 2610**

Alternatively, you can return this form to one of our service centres.

If you have any questions about this form, call us on **132 717**.

**Important** – This request is a notice given under section 63 of the *Social Security (Administration) Act 1999*.

### Privacy and your personal information

Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the department or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law.

You can get more information about the way in which the Department of Human Services will manage your personal information, including our privacy policy, at **humanservices.gov.au/privacy** or by requesting a copy from the department.

## Information for the doctor

### Completing this form

In this form you will be asked to provide information about your patient's medical condition(s). Please complete all the required questions in this form.

If your patient is **temporarily incapacitated for all work of at least 8 hours per week**, please complete a Medical Certificate instead of this form. You can complete and lodge Medical Certificates electronically through Health Professional Online Services (HPOS). For more information go to **humanservices.gov.au/healthprofessionals** and logon to HPOS.

If you require another copy of this form, go to **humanservices.gov.au/forms**

If you need more information in order to complete this form call us on **132 150**.

### Request for clarification of additional information

The Department of Human Services, including staff from the Health Professional Advisory Unit, may make contact with you to discuss the information in this form. These contacts will only occur where information requires clarification.

### Reimbursement for services

We have asked your patient to let you (and your receptionist) know at the time of making their appointment that they require you to complete this form. This is to make sure that you have sufficient time for the examination and completion of the report. The time taken to complete this report counts towards the length of the consultation. You can claim it as a long consultation.

### Release of medical information

The *Freedom of Information Act 1982* allows for the disclosure of medical or psychiatric information directly to the individual concerned. If there is any information in this form which, if released to your patient, may harm his or her physical or mental well-being, please attach a statement identifying it and briefly state why it should not be released directly to the patient. Similarly, please specify any other special circumstances which should be taken into account when deciding on the release of this form.

### Returning this form

You can give this form to your patient or return it directly to:

**Department of Human Services**
**Disability Services**
**Reply Paid 7806**
**CANBERRA BC ACT 2610**

**Thank you for your assistance.**

Instructions Print Clear

**Patient's details**

Family name

Given name(s)

Address

Postcode

Date of birth / /

Centrelink Reference Number – –

**Condition 1** **Condition 2** **Condition 3**

**Diagnosis** — Please list the main medical conditions which **significantly impact** on the patient's capacity to work

**Date of onset** (if known) / /

**Assessment** — **1 –** Temporary, **2 –** Permanent (likely to persist for 2 years or more), **3 –** Prognosis unclear

***Tick ONE only*** 1 ☐ 2 ☐ 3 ☐

**Symptoms** — Please list current symptoms for each condition

**Treatment** — Please describe the patient's treatment regime, including past, current and planned treatment

Past:

Current:

Planned:

**Other medical conditions** — Please give details of any other conditions which significantly impact on the patient's capacity to work or study

**Recommended assistance** — Please list any interventions that could help the patient into work or stay in a job

**Details of doctor completing this form**

Doctor's name (printed)

Professional qualifications

Provider no.

Surgery/Medical Centre/ Hospital name

Address

Postcode

Phone number ( )

Signature

Date / /

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## IMPORTANT INFORMATION FOR THE DOCTOR OR MEDICAL SPECIALIST

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