



Veteran

--

UIN

--

An Impairment Assessment aims to determine the impact of the veteran's service-related medical conditions. The Impairment Assessment asks for information such as:

- the severity of the disease
- previous and current treatment
- the veteran's functional status
- a small number of examinations findings
- common investigation results.

Permanence

Permanent means there is impairment that is **likely to continue indefinitely**.

- Most chronic and degenerative diseases would be considered to have permanent impairment from the date of diagnosis.
- Acute conditions and injuries are not usually considered to have permanent impairment unless there is residual impairment once treatment and recovery are finalised.

1. Please complete the following table about the **permanence** of the conditions. New conditions contributing to this impairment should also be included.

Condition	Has the condition resolved completely?	If not, is the impairment likely to resolve in the foreseeable future?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Stability

Stable means the impairment is **unlikely to improve to a significant degree**.

- The impairment arising from a condition is not likely to be considered stable if there has been a recent exacerbation of symptoms, a significant change in a treatment regime or if there is pending surgery.
- A condition can still be considered to have stable impairment if it has a fluctuating course (e.g. mental health conditions), or if it presents intermittently (e.g. asthma, migraines etc.).

If the impairment is not currently stable, please provide an estimate of when this should be reviewed. That is, how long will it take for any treatment changes to take effect and for the impairment to return to baseline.

2. Please complete the following table about the **stability** of conditions.

Condition	Is the impairment arising from the condition stable?	If 'Yes' what is the Date of Stability (DD/MM/YY)	If 'No' when should the condition be reviewed (months)
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Treatment

Understanding what treatment the veteran has undertaken, and what further treatments are available, is a key consideration in the assessment of permanent impairment.

3. Please provide details of **all treatment** (including medication, specialist review, surgery, allied health input, aids and appliances, etc.) that has been **received** so far for each condition.

Condition	What treatment has the client received so far?

4. List any other **treatment** options, which are **likely to improve the veteran's level of function**. Treatment aimed at maintaining the current disease status, or preventing progression or complications, does not need to be included. More severe impairment may require consideration of more intensive treatment.

If further treatment is identified, please estimate the **percentage improvement expected** if the treatment is undertaken.

Condition	Treatment likely to improve the function		Expected improvement
	Nil	Specify below:	%
	<input type="checkbox"/>	

Condition	Treatment likely to improve the function		Expected improvement
	Nil	Specify below:	%
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

5. Are there any other comments you would like to make regarding treatment?

.....

.....

.....

.....

Doctor's signature	Doctor's name	Date	Time to complete form
--------------------	---------------	------	-----------------------