Australian Government
Department of Veterans' Affairs

Upper Gastrointestinal Tract Condition(s)
Medical Impairment Assessment

Veteran	UIN

Please assess the following conditions:

1. Please select the most accurate description of any **difficulty** with **chewing** and/or **swallowing**.

Description	Select One
None.	☐
Some difficulty chewing or swallowing, **minor** or **occasional restriction of diet**.	☐
Significant difficulty in chewing or swallowing, but **diet is not grossly restricted**.	☐
Difficulty in chewing or swallowing that limits **diet to soft or semi-solid foods**.	☐
Diet limited to liquid or pureed food due to difficulty in chewing or swallowing.	☐

2. Please select the most accurate description of any **interventions** related to **dysphagia**.

Description	Select One
None.	☐
Constant dysphagia requiring **dilation two to five times a year**.	☐
Constant dysphagia necessitating **dilation six times or more a year**.	☐
Other (please describe).	☐

3. Please select the most accurate description of any **gastro-oesophageal reflux**.

Description	Select One
None.	☐
Mild and/or occasional symptoms.	☐
Frequent minor symptoms necessitating use of **medication**.	☐
Moderate or **severe symptoms** on most days **despite regular medications**.	☐

4. Please select the most accurate description of any **oesophagitis**.

Description	Select One
None.	☐
Active disease with **moderate symptoms** on most days **despite regular medication**.	☐
Active disease with **complications.** e.g. Barrett's epithelium, blood loss, aspiration or stricture.	☐

5. Please select the most accurate description of any **non-ulcer dyspepsia, nausea** and/or **vomiting.**

Description	Select One
None.	☐
Infrequent and **mild**.	☐
Mild to moderate necessitating some **medication on most days**.	☐
Moderate symptoms necessitating **daily medication**.	☐
Uncontrolled despite medication.	☐

6. Please rate the most accurate description of any **peptic ulceration**.

Description	Select One
None.	☐
History of peptic ulcer with **no current symptoms**.	☐
Intermittent symptoms necessitating **ongoing maintenance treatment**.	☐
Active disease with **moderate symptoms** on most days **despite medication**.	☐
Endoscopically proven active disease with **complications** e.g. bleeding or outlet obstruction and **troublesome daily symptoms**.	☐

7. Please rate the most accurate description of the effect of any **gastric surgery**.

Description	Select One
No previous surgery.	☐
No current symptoms.	☐
Intermittent dyspepsia and/or **mild dumping syndrome**.	☐
Frequent dyspepsia and/or **frequent dumping syndrome**.	☐
Severe dyspepsia and/or **dumping syndrome** on **most days**.	☐

8. Are there any other comments you would like to make regarding the impact of the veteran's upper gastrointestinal condition(s)?

.....

.....

.....

.....

9. Please list **all conditions** contributing to the reported impairment and indicate the **percentage contribution**. Include any previously known condition(s) and any new condition(s) you have identified. The contribution total must equal 100%.

Condition	**Contribution %**
e.g. Chronic Gastropathy	75%
Total	**100%**

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

Save Print Clear