

Injury or disease details sheet

Surname	Given name(s) DVA file number(s) (if known)			
NOTE: This is not a claim form and must be used as an attachment to either the D2020 <i>Claim for Rehabilitation and Compensation</i> or D2051 <i>Claim for Liability and/or Reassessment of Compensation</i> .				
This section to be filled in by the claimant				
Please fill out one sheet per injury complete this sheet.	or disease for which yo	ou are now clai	ming liability. If this is a reassessm	nent, do not
Please detail the injury or disease you you notice the disability (e.g. pain in	ower back, shortness of	of breath, loss	of range of movement in right arm)	
You are requested to ask your doctor	to fill in the Medical Pr	ractitioner secti	on on the next page before lodging	g your claim.
Injury or disease				
Signs and symptoms				
How do you believe your service caused, contributed to or aggravated this injury or disease?	If insufficient space,	nlassa attach	a conarata cheat	
When did the injury happen (if applicable)?	/ /	, piease attacii	a separate sneet	
Has a Defence injury report been completed?	No ☐ Yes ☐▶	@ Please	attach the Defence injury report.	Do not know
When did you first notice signs or symptoms of the injury or disease?	/ /			
On what date did you first receive medical treatment for this injury or disease?	/ /	(if	known)	
Name of your treating medical practitioner/hospital/ specialist	For claimed condition	ons		
Type of treatment or consultation provided (e.g. GP, specialist)				
Has this injury or disease worsened or been aggravated since 1 July 2004?	No Yes			
Is a medical practitioner's account attached in relation to completion of this injury or disease details sheet?	No Yes			

Privacy notice

Your personal information is protected by law, including the *Privacy Act 1988*. Your personal information may be collected by the Department of Veterans' Affairs (DVA) for the delivery of government programs for war veterans, members of the Australian Defence Force, members of the Australian Federal Police and their dependants.

Read more: How DVA manages personal information

INJURY OR DISEASE DETAILS SHEET continued DVA file number(s) (if known) Surname Given name(s) This section to be filled in by a medical practitioner Please supply a brief summary of the basis for each diagnosis and attach any reports you have that confirm the diagnosis. DVA will pay you for this service according to the relevant fee levels for the service. NOTE: The claim for this condition must be lodged before payment of medical account can be made. Medical diagnosis Basis for diagnosis Is this diagnosis Confirmed Provisional When did the claimant first consult you for this injury or disease? Please advise approximate date of onset of the injury or disease based on available notes Address **POSTCODE** Telephone] Medical practitioner stamp (Please include Provider Number) **MEDICAL PRACTITIONER'S SIGNATURE** Date (T)