Medical practitioner report

Super SA

Government of South Australia

For all schemes

Please complete all the details on this form in **BLOCK LETTERS** using a **BLACK PEN** and return the signed original to Super SA.

Who completes this form?
This medical report is to be completed by your usual treating doctor, for most this is their regular GP.

To find out more visit **supersa.sa.gov.au** or call **(08) 8214 7800**.

Client ID:

For TPD & TI - Super SA requires a Medical Report to be completed by a Specialist Medical Practitioner (as registered with AHPRA) in the relevant field.
For IP - Super SA may require a Specialist Medical Practitioner (as registered with AHPRA) to complete a Medical report to assess your claim, it is highly recommended to have this report completed when submitting your claim.

1. Patient's details

Title

Given Name(s)

Family Name

Date of birth D D / M M / Y Y Y Y

2. Diagnosis

Are you the patient's usual doctor? ☐ Yes ☐ No If Yes, from what date? D D / M M / Y Y Y Y

If applicable, what date is your next appointment with the patient? D D / M M / Y Y Y Y

What are the patient's current symptoms they are presenting with?

What are all the diagnosed injury/condition(s) causing incapacity for work?

Important
Please be aware ambiguous answers (including unclear or guarded prognoses) will require this form to be completed again with more detail.

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2. Diagnosis (continued)

When did your patient first consult you about their current injury or condition?

Injury or condition	Date first suffered
1.	D D / M M / Y Y Y Y
2.	D D / M M / Y Y Y Y
3.	D D / M M / Y Y Y Y
4.	D D / M M / Y Y Y Y
5.	D D / M M / Y Y Y Y

Please list any other current or related medical conditions (in order of severity with 1 being most severe, 3 being least).

Conditions and treatment	Condition 1	Condition 2	Condition 3
What are the main incapacitating condition(s)* the patient is suffering from? **please attach additional information if there are 4 or more conditions*			
Is there a diagnosis linked to the condition(s)? If Yes, please provide details.			
When did the patient first suffer the condition(s)? [dd mm yyyy]	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
What are the patient's symptoms for the condition(s)?			
Provide details of investigation and/or tests. *(please attach all results)*			
How are the condition(s) affecting the patient's capacity to perform work duties?			
What is the patient's prognosis? Provide details of treatment for the condition(s).			

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2. Diagnosis (continued)

What other related medical condition(s) is the patient suffering from, that impacts on the patients ability to work?

What is preventing the patient from working now?

Can the patient work now?

☐ Yes Provide details of the patient's capacity to work:

☐ Part time _____ hours per week _____ days per week

OR

☐ Full time

☐ No When do you think the patient may be able to return to work? D D / M M / Y Y Y Y

What rehabilitation or steps are required to support the patient returning to work?

Provide details of relevant investigations and/or tests (please attach all results).

Detail how the injuries or condition(s) affect the patient's ability to perform work duties.

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2. Diagnosis (continued)

Is your patient's condition terminal? ☐ Yes ☐ No

If yes, in your view is the condition likely to be terminal within ☐ Less than 2 years ☐ 2-5 years ☐ Longer than 5 years

Please outline any other comments you believe may be relevant to the patient's diagnosis.

3. Treatment

What treatment (including but not limited to medication) have you or any other medical practitioner provided your patient for the injury/condition since the injury/condition was diagnosed?

Has the patient been engaging with the recommended treatment? If they haven't, please provide detail.

List relevant investigations used to diagnose and manage the injury/condition (including imaging studies).

What was the patient's response to the treatment intervention listed above?

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3. Treatment (continued)

Please list any other medical practitioners or rehabilitation interventions linked to your patient's management.

Name	Speciality	Location	Date of referral
			D D / M M / Y Y Y Y
			D D / M M / Y Y Y Y
			D D / M M / Y Y Y Y

Please outline any other comments you believe may be relevant to the patient's treatment.

4. Capacity for work

Based on your professional medical opinion please answer the following questions:

Is your patient fit for their usual occupation?

Full time (30 hours plus) ☐ Yes ☐ No

Part time (15-30 hours) ☐ Yes ☐ No

Physical nature of their usual work: ☐ Light ☐ Moderate ☐ Heavy

If your patient is not currently fit for their usual occupation, when are they likely to resume their usual occupation? D D / M M / Y Y Y Y

Please provide details:

Is your patient fit for any other alternative work (including sedentary)?

Full time (30 hours plus) ☐ Yes ☐ No

Part time (15-30 hours) ☐ Yes ☐ No

Physical nature of their alternative work: ☐ Light ☐ Moderate ☐ Heavy

If your patient is not currently fit for alternative work when are they likely to be able to undertake alternative work (if ever)? D D / M M / Y Y Y Y

If no date can be provided, is the patient unlikely, as a result of their injury/ condition, in your opinion to at any future time engage in gainful employment? ☐ Yes ☐ No

Please provide details including what medical treatment, rehabilitation, training or other steps may be required to return to any type of work.

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4. Capacity for work (continued)

If it is premature to express an opinion about when your patient could return to work, please provide an estimate as to when an opinion could be expressed D D / M M / Y Y Y Y

Please estimate your patient's overall level of **capacity to undertake all kinds of work**. Please circle only one.

0 10 20 30 40 50 60 70 80 90 100%

(0% capacity means your patient is completely unable to perform any type of work. 100% capacity means your patient can perform any type of work)

Important - To assist with the assessment of this claim, please attach copies of any documentation you hold regarding your patient's injury/condition. This may include:

- List of current medications
- Specialists Reports
- Any Test Results (eg biopsy/blood)
- Health Care Plans
- Orthopaedic/Radiological Reports (eg X-rays/MRI)
- Hospital or Separation Reports
- Workers' compensation
- Return to Work Reports

Important - This form must only be completed by a specialist as listed with AHPRA.

5. Medical practitioner declaration

- I confirm that I am a currently registered medical practitioner with the AHPRA under a general or specialist registration and I am NOT holding limited or provisional registration.
- I hereby certify that I have personally attended the patient and that all the information supplied by me on this form is true and correct.
- I understand that Super SA and its medical adviser(s) will use this information and
- Super SA may provide copies of this report to the patient or to any medical practitioner, or to any other person deemed necessary to assist in the assessment of this claim.

Medical practitioner stamp

Name of medical practitioner

Name of practice

Street address

Suburb State Postcode

Contact number Email address

AHPRA Registration Number Provider number

Signature ✘ Date D D / M M / Y Y Y Y

Contact us

EMAIL medicalsuper@sa.gov.au
WEBSITE supersa.sa.gov.au
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POST GPO Box 48, Adelaide SA 5001
MEMBER CENTRE (Appointment preferred) 151 Pirie St Adelaide SA 5000

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