



#### 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 treating specialist medical practitioner.

Ta	find out	more visit super		coall (09) 934/ 7	900
പറ	tina out	' more visit <b>suber</b> !	sa.sa.dov.au oi	r call <b>(OB) 821/. /</b>	800.

For IPD & II - 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 DDD/MM/M/YYYYY
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?  What are the patient's current symptoms they are presenting with?
What are all the diagnosed injury/condition(s) causing incapacity for work?

OFFICIAL: SENSITIVE (when completed)

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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	Inuea) Ilt you about their current injury or co		
Injury or condition		Date 1	first suffered
1.		D	D / M M / Y Y Y Y
2.		D	
3.			
4.			D / M M / Y Y Y
5.		D	D / M M / Y Y Y
Please list any other current or rel	ated medical conditions (in order of se	verity with 1 being most severe, 3 being	g 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]	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
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	g the patient from work	ina now?				
Free Processing	, F	9				
Can the nations w	ork nou?					
Can the patient w	Provide details of the p	nationt's canacity to	work:			
103	Part time	outient's capacity to	hours per week		days per week	
OR	Full time		'		, ,	
	Full time					
No	When do you think th	e patient may be ab	e to return to work	? D D / M	M / Y Y Y	
What rehabi	litation or steps are rec	juired to support the	patient returning	to work?		
Provide details of	relevant investigations a	and/or tests (please a	ttach all results).			
Detail how the inju	ries or condition(s) affe	ct the patient's ability	to perform work d	uties.		
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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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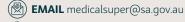
This medical report is to be completed by your treating specialist medical practitioner.

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Please estim	nate your pati	ent's overall l	evel of <b>capac</b>	ity to undert	ake all kinds	of work. Plea	se circle only	one.		
0	10	20	30	40	50	60	70	80	90	100%
(0% capacity n	neans your patie	ent is completely	unable to perf	orm any type o	f work. 100% ca	pacity means yo	our patient can <sub>l</sub>	perform any ty	pe 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

<ul> <li>Specialist medical practitioner de la confirm that I am a currently registered medical practitioner with the AHPRA under a specialist registration and I am NOT</li> </ul>	Specialist medical practitioner stamp
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	
<ul> <li>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.</li> </ul>	
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Contact us



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**PHONE** (08) 8214 7800



MEMBER CENTRE (Appointment preferred) 151 Pirie St Adelaide SA 5000