Form 1a: Imminently Fatal Asbestos-Related Disease

Medical Certificate

Approved Form – AF2017-156 under s222 of the Workers Compensation Act 1951 for the purpose of a person making a claim under s170(2) of the Workers Compensation Act 1951

The Default Insurance Fund is the compensation provider for ACT workers that have contracted an asbestos-related disease through their employment in the ACT.

Please complete all relevant sections of the form. 'As previous' or 'Unchanged' is not considered sufficient information. Where the worker has completed an authority for the release of medical information, please send all relevant test results , scans and reports to the Default Insurance Authority, by electronic means where possible (email). This will assist with processing the worker's claim in a timely manner.

WORKER DETAILS

Title (Mr/Mrs/Ms/Miss/Other) Date of Birth

Last Name

Given Name(s)

Home Address

Suburb State Postcode

Postal Address if same as home address write 'same as above'

Suburb State Postcode

Telephone numbers Home Work

Mobile

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MEDICAL CERTIFICATION

I examined the patient on

Current clinical symptoms

Diagnosis of the asbestos-related disease is:

Based on the patient history, in my opinion the disease is:

☐ reasonably attributable to workplace exposure (state reasons)

☐ or other cause

If known, is the disease a new disease/condition?

☐ Yes ☐ No Provide details

Past history of similar diseases/conditions or comments relevant to disease/condition

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I am of the opinion that the patient is:

☐ not reasonably likely to die within 2 years from the date on which this certificate is given (non-imminently fatal asbestos-related disease)

☐ reasonably likely to die within 2 years from the date on which this certificate is given, but the asbestos-related disease is not likely to be a substantial contributing factor to the worker's death (non-imminently fatal asbestos-related disease)

☐ reasonably likely to die within 2 years from the date this certificate is given and the asbestos-related disease is reasonably likely to be a substantial contributing factor to the workers' death

Provide full details of any other medical condition/s that may contribute to the person's death (if applicable)

INCAPACITY / FITNESS FOR WORK (complete where relevant)

The patient is currently;

☐ fit to continue duties

☐ fit to return to duties from

☐ fit for modified duties, with limitations specified below from to

☐ already retired from employment

Restrictions

☐ totally unfit for work from to due to:

(Please specify grounds for opinion)

☐ The patient has wholly/substantially recovered from the effects of the asbestos-related disease

☐ The patient's incapacity is no longer due wholly/substantially to the asbestos-related disease

(Please specify grounds for opinion)

Provide test results, xrays, scans, and/or examinations conducted upon which the diagnosis and/or findings of causation are based. These must be recent (i.e. within 6 months).

In addition, for non-malignant cases, provide full lung function testing including spirometry and gas transfer results.

CURRENT MEDICAL TREATMENT SUMMARY (treating medical specialist or doctor to complete)

What type of medical treatment or pharmaceutical treatment is currently required for this disease?

Treatment type	Benefits of treatment	Date of review	Number of sessions

Provide details of any other medical services, nursing services, hospital services, rehabilitation services, ambulance services, constant attendance services, physiotherapy services or psychological services required for the treatment of the disease, include expected duration of treatment where applicable.

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Has the patient been referred to another health/medical professional? If yes, provide details.

Has the patient consulted other health/medical professionals? If yes, provide details.

MEDICAL PRACTITIONER DETAILS

Name and address of registered medical practitioner (please print)

Name

Postal address

Postcode

Phone

Fax

Qualifications

Specialty

Occupation

Provider number

Signature

Date

SUBMIT COMPLETED FORM

BY post to:

Default Insurance Fund (DIF)
GPO Box 158
Canberra ACT 2601