MEDICAL REPORT

FOR ACCIDENTS ON OR AFTER 1 FEBRUARY 2020

ACT Government | Motor Accident Injuries Commission

To be completed by a doctor, and submitted with a *Personal Injuries* application.

1. Patient details

Patient's first name

Middle name(s)

Last name

Date of birth (dd/mm/yyyy)

Occupation

Medicare number and reference number

Date of the motor accident

Date patient first attended in relation to the accident

How long has the patient attended the practice? (if applicable)

2. Patient's motor accident injury details

Did the patient attend hospital after the accident?

☐ No ▶ **If no,** skip to the next question.

☐ Yes ▶ **If yes,** please give the hospital and ambulance details below (if applicable).

Name of the hospital

Was the patient attended by an ambulance?

☐ No ☐ Yes

Has the patient been discharged from hospital? (dd/mm/yyyy)

☐ No ☐ Yes, discharged on

Medical diagnosis or description of the injury

Are the injuries consistent with the circumstances of the motor accident described to you?

☐ Yes ☐ No

Clinical findings (symptoms, investigation results)

3. Pre-existing conditions

Has the patient been treated for a similar condition or had an injury in a similar area in the past?

☐ Unknown ▶ **If unknown,** skip to the next question.

☐ Known ▶ **If known,** please give details:

Has a pre-existing injury become aggravated by the accident?

☐ Unknown ▶ **If unknown,** skip to the next question.

☐ Known ▶ **If known,** please give details:

4. Treatment

Is treatment likely to be required:

☐ No treatment necessary

☐ Short term (up to 4 weeks)

☐ Medium term (4-13 weeks)

☐ Long term (>13 weeks)

Treatment type:

☐ GP management

☐ Allied Health Therapy

☐ Specialist

☐ Other

Treatment plan, referrals (including provider details), recommendations and advice to patient (including details of any treatment / rehabilitation already undertaken):

5. Fitness for work

Note: A certificate is to cover a prospective period of up to one month. Please attach a statement if you consider that a certificate should cover a longer period to satisfy the insurer the longer period is acceptable. A certificate cannot be back-dated more than 13 weeks. A review date is to be on or before the expiry of this certificate.

Is the patient fit for work?

☐ Yes, fit for work in previous role with no restrictions ▶ **Skip to section 6.**

☐ Yes, with reduced capacity ▶ **From:** / / **until:** / / **Date of next review:** / /

Hours, duties and types of work that can be performed:

☐ No, patient unfit for work ▶ **From:** / / **until:** / / **Date of next review:** / /

Please indicate an anticipated timeframe for recovery, and factors impacting the person's ability to recover

6. Doctor's information

Doctor's name

Work phone number

Specialty

Provider Number

If stamp available, place here:

Name of practice / hospital

Practice / hospital address

☐ **I agree to be the treating doctor nominated for the ongoing management of the patient's treatment and recovery from their motor accident injuries.**

7. Declaration

I declare that I am a registered medical practitioner and to the best of my knowledge, the information given in this form is true and correct.

Signature

Date (dd/mm/yyyy) / /

Authorised by: **ACT Government | Motor Accident Injuries Commission**

Catalogue No. MAIMR05 05/22