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| --- | --- | --- | --- | --- | --- | --- | --- |
| Australian Government crest, Department of Veterans' Affairs branding | Thoraco-lumbar Spine Function  Medical Impairment Assessment | | | | | | |
| Veteran | | | |  | UIN | | |
|  | | |  |  | | | | |
|  | | | |  |  | | |
| Please assess the following conditions: | | | | | | | | |
|  | | | | |  |  | |

1. Please complete either Table A **or** Table B in relation to the **Range of Movement (RoM)**.

**Table A:** Select the most accurate description of any loss of active RoM at the thoraco-lumbar spine. (Consider motion in all planes with emphasis on those of functional importance).

| **Description** | **Select One** |
| --- | --- |
| **None or minor** restriction of movement. |  |
| Loss of about **one-quarter** range of movement. |  |
| Loss of about **half** range of movement. |  |
| Loss of about **three-quarters** range of movement. |  |
| Loss of **nearly all** movement / **ankylosis** in position of function. |  |
| **Ankylosis** in an **unfavourable position.** |  |

**Table B:** Enter the measured RoM in each plane.

| **Movement** | **Normal RoM** | **Right** | **Left** |
| --- | --- | --- | --- |
| Rotation. | 30° |  |  |
| Lateral Flexion. | 30° |  |  |
| **Movement** | **Normal RoM** | **Sagittal Plane** | |
| Flexion. | 90° |  | |
| Extension. | 30° |  | |

1. Please identify the presence of **any crush fractures** of the thoracolumbar vertebrae.

| **Description** | **Select One** |
| --- | --- |
| None. |  |
| **Minor compression** (less than 25%) of **one or more vertebrae**. |  |
| **Moderate compression** (25-50%) of **one vertebrae**. |  |
| **Moderate compression** of **two or more vertebrae**. |  |
| Compression of greater than 50% of **one or more vertebrae**. |  |

1. Please select the most accurate description with any **difficulty sitting or standing** (only include the impact of thoracolumbar spine conditions).

| **Description** | **Select One** |
| --- | --- |
| **No difficulties** in sitting or standing or other everyday activities. |  |
| **Occasional difficulties** with prolonged sitting or standing. |  |
| Difficulties generally result in **pain or undue fatigue by the end of the day**. |  |
| Pain or undue fatigue **within half an hour**, and so **requires frequent changes in posture.** |  |
| Pain or undue fatigue **within five minutes**, and so **requires very frequent changes of posture**. |  |

1. Please select the most accurate description of any **resting joint pain** (pain which is present in the absence of use of the joint, or which persists beyond the expected recovery period).

| **Description** | **Select One** |
| --- | --- |
| None or **not usually present** at rest. |  |
| **Mild** pain that is **often present** at rest. |  |
| Pain that is **often** **present** at rest but **improves** after several hours or responds to medication or to therapeutic measures. |  |
| **Severe** pain that is **often present** at rest but **does not respond adequately** to medication or to therapeutic measures. |  |
| **Severe** pain that is **always present** at rest but **does not respond adequately** to medication or therapeutic measures AND **regularly interferes with sleep**. |  |

1. Please list **all conditions** contributing to the reported impairment and indicate the **percentage contribution**. Include any previously known condition(s) and any new condition(s) you have identified. The contribution total must equal 100%.

| **Condition** | **Contribution %** |
| --- | --- |
| e.g. Lumbar Spondylosis | 75% |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Total** | **100%** |

|  |  |  |  |
| --- | --- | --- | --- |
| Doctor's signature | Doctor's name | Date | Time to complete form |
|  |  |  |  |