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| --- | --- | --- | --- | --- | --- | --- |
| Australian Government crest, Department of Veterans' Affairs branding | Haematological Condition(s)  Medical Impairment Assessment | | | | | |
| Veteran | | | |  | UIN |
|  | | |  |  | | |
|  | | | |  |  |
| Please assess the following conditions: | | | | | | |

1. Please select the most accurate description of the need for **cytotoxic therapy**.

| **Description** | **Select One** |
| --- | --- |
| None, or less often than monthly. |  |
| One course every 3-4 weeks, or more often. |  |

1. Please select the most accurate description of the need for **transfusions or infusions**.

| **Description** | **Select One** |
| --- | --- |
| None, or less frequently than every 4 months. |  |
| Every 12-16 weeks. |  |
| Every 6-8 weeks. |  |
| Every 4 weeks. |  |
| Every 2 weeks or more. |  |

1. Please select the most accurate description of the need for **therapeutic phlebotomy.**

| **Description** | **Select One** |
| --- | --- |
| None, or less often than once every 4 weeks. |  |
| Once every 4 weeks. |  |
| More than once every 4 weeks. |  |

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. Chronic Lymphocytic Leukaemia | 75% |
|  |  |
|  |  |
|  |  |
|  |  |
| **Total** | **100%** |

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