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| Australian Government crest, Department of Veterans' Affairs branding | Renal FunctionMedical Impairment Assessment |
| Veteran |  | UIN |
|  |  |  |
|  |  |  |
| Please assess the following conditions:  |

1. Does the veteran have diagnosed **renal artery stenosis**? [ ] Yes [ ] No
2. Please select the most accurate description of the prognosis of any **glomerulonephritis.**

| **Description** | **Select One** |
| --- | --- |
| No glomerulonephritis. |[ ]
| **Good prognosis** expected. |[ ]
| Likely to cause chronic renal failure in **5 – 10 years**. |[ ]
| Likely to cause chronic renal failure in **6 months – 5 years**. |[ ]
| Likely to cause chronic renal failure in **less than 6 months**. |[ ]

1. Please select the most accurate description of any **chronic renal failure**.(Use of eGFR to estimate creatinine clearance is sufficient)

| **Description** | **Select One** |
| --- | --- |
| Creatinine clearance of **greater than 20mL/min**. |[ ]
| Creatinine clearance of **less than 20mL/min**. |[ ]
| Creatinine clearance of **less than 10mL/min**. |[ ]
| Ongoing **peritoneal dialysis** or **haemodialysis**.  |[ ]

1. Has the veteran undergone a **nephrectomy**? [ ] Yes [ ] No
2. Has the veteran undergone a **renal transplant**? [ ] Yes [ ] No
3. Please select **all** that apply in relation to any **hydronephrosis**.

| **Description** | **Select** |
| --- | --- |
| None. |[ ]
| One or more episodes more than 12 months ago. |[ ]
| Hydronephrosis within the last 12 months **due to an upper urinary tract disorder**. |[ ]
| Hydronephrosis within the last 12 months **due to a lower urinary tract disorder**. |[ ]

1. Please select **all** that apply in relation to any **urinary tract infections**.

| **Description** | **Select** |
| --- | --- |
| None. |[ ]
| Occasional UTIs. |[ ]
| **Recurrent cystitis** causing frequent symptoms. |[ ]
| **Pyelonephritis** within the last 12 months **due to an upper urinary tract disorder**. |[ ]
| **Pyelonephritis** within the last 12 months **due to a lower urinary tract disorder**. |[ ]

1. Does the veteran have **renal stone disease**? [ ] Yes [ ] No
2. Please select the most accurate description of any **bladder outlet** or **urethral obstruction**.

| **Description** | **Select One** |
| --- | --- |
| None. |[ ]
| **Mild** symptoms e.g. poor stream or hesitancy. |[ ]
| **More severe** symptoms e.g. urge frequency, nocturia, recurrent UTIs. |[ ]
| **Urethral stricture** necessitating passage of sounds at intervals of 3 months or less. |[ ]
| **Loss of voluntary control** but emptying achieved by **techniques to trigger voiding**. |[ ]
| **Loss of voluntary control,** necessitating **intermittent catheterisation**. |[ ]
| **Urinary diversion**,e.g. ileal conduit, has been undertaken. |[ ]

1. Please select the most accurate description of any **incontinence**.

| **Description** | **Select One** |
| --- | --- |
| None. |[ ]
| **Occasional stress** incontinence**,** pads not needed. |[ ]
| **Minor** **stress** incontinence, needing use of 1-2 incontinence pads a day. |[ ]
| **Mild urge** incontinence, but rarely unable to find a toilet in time. |[ ]
| **Moderate** **stress** incontinence, needing several incontinence pads a day. |[ ]
| **Frequent and severe stress** incontinence, causing significant embarrassment and some avoidance of social activities and public places. |[ ]
| **Dribbling incontinence** needing frequent change of incontinence pads, or a collection device, e.g. condom catheter. |[ ]
| Incontinenceneeding **a permanent indwelling catheter**. |[ ]
| **Urinary diversion**,e.g. ileal conduit, has been undertaken. |[ ]

1. Are there any other comments you would like to make regarding the impact of the veteran’s urinary tract condition(s)?

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. Diabetic nephropathy | 75% |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Total** | **100%** |

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