|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Australian Government crest, Department of Veterans' Affairs branding | Intermittent Condition(s)  Medical Impairment Assessment | | | |
| Veteran | |  | UIN |
|  | |  |  | |
|  | |  |  |
| Please assess the following conditions:  For this assessment, each condition needs to be assessed in **isolation** from all others. This means that when assessing a condition, you will need to assess the impairment **as though only that single condition is present**, and that the veteran is otherwise healthy and normal. | | | | |

1. What is the **frequency** (days per year) and **duration** (length of time) of each type of episode or attack that the veteran experiences, due to each condition *in isolation*. If the condition(s) present with variably intensity, please use the average.

| **Condition** | **Frequency of episodes**  (days per year) | **Duration of episodes**  (length of time) |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |

1. Please indicate if the condition(s) cause the veteran to be **confined** to a **residential care** facility?

| **Condition** | **Select “Yes” or “No”** |
| --- | --- |
|  | Yes  No |
|  | Yes  No |
|  | Yes  No |

1. On the following page, please rate how each condition, *in isolation*, affects each of the following **activities of daily living** (ADL)when present, using the following scale. If the condition(s) present with variable severity, please select an average rating**.** The examples below are not exhaustive and should be used as a reference point to identify similar activities.

|  |  |
| --- | --- |
| **None** | No interference with activity |
| **Minor** | Minor interference with activity |
| **Moderate** | Interference with activity |
| **Major** | Significant interference with activity |
| **Extreme** | Assistance required to perform activity |

| **Description** | Insert condition: | Insert condition: | Insert condition: |
| --- | --- | --- | --- |
| **Normal activities**  (e.g. usual domestic and community ADLs) | None  Minor  Moderate  Major  Extreme | None  Minor  Moderate  Major  Extreme | None  Minor  Moderate  Major  Extreme |
| **Ability to receive and respond to incoming stimuli**  (e.g. visual and auditory processing, response to touch, maintaining concentration, responding appropriately, etc.) | None  Minor  Moderate  Major  Extreme | None  Minor  Moderate  Major  Extreme | None  Minor  Moderate  Major  Extreme |
| **Standing** (e.g. standing up, standing still, etc.) | None  Minor  Moderate  Major  Extreme | None  Minor  Moderate  Major  Extreme | None  Minor  Moderate  Major  Extreme |
| **Moving** (e.g. transfers, walking, climbing stairs, navigating crowds, using public transport etc.) | None  Minor  Moderate  Major  Extreme | None  Minor  Moderate  Major  Extreme | None  Minor  Moderate  Major  Extreme |
| **Feeding** (e.g. cutting food, eating, swallowing, etc., but not the preparation of food) | None  Minor  Moderate  Major  Extreme | None  Minor  Moderate  Major  Extreme | None  Minor  Moderate  Major  Extreme |
| **Control of bowel and bladder**  (e.g. toileting, awareness of needing to void, incontinence, etc.) | None  Minor  Moderate  Major  Extreme | None  Minor  Moderate  Major  Extreme | None  Minor  Moderate  Major  Extreme |
| **Self-care**  (e.g. bathing and dressing) | None  Minor  Moderate  Major  Extreme | None  Minor  Moderate  Major  Extreme | None  Minor  Moderate  Major  Extreme |
| **Sexual Function** (e.g. orgasm, ejaculation, lubrication, etc.) | None  Minor  Moderate  Major  Extreme | None  Minor  Moderate  Major  Extreme | None  Minor  Moderate  Major  Extreme |

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

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