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| --- | --- | --- | --- | --- | --- |
| Australian Government crest, Department of Veterans' Affairs branding | Gastrointestinal Condition(s)  Medical Impairment Assessment  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. Please describe the current **signs, symptoms and investigation findings,** related to each condition *in isolation.*

| Insert condition: | |
| --- | --- |
| **Signs** (e.g. fever, unexplained weight loss, abdominal distension or tenderness.) |  |
| **Symptoms,** including **frequency and severity** (e.g. abdominal pain, bowel changes, vomiting.) |  |
| **Investigation Findings** (e.g. anaemia on laboratory testing, oesophagitis on gastroscopy, diverticulitis on CT scan.) |  |

| Insert condition: | |
| --- | --- |
| **Signs** (e.g. fever, unexplained weight loss, abdominal distension or tenderness.) |  |
| **Symptoms,** including **frequency and severity** (e.g. abdominal pain, bowel changes, vomiting.) |  |
| **Investigation Findings** (e.g. anaemia on laboratory testing, oesophagitis on gastroscopy, diverticulitis on CT scan.) |  |

| Insert condition: | |
| --- | --- |
| **Signs** (e.g. fever, unexplained weight loss, abdominal distension or tenderness.) |  |
| **Symptoms,** including **frequency and severity** (e.g. abdominal pain, bowel changes, vomiting.) |  |
| **Investigation Findings** (e.g. anaemia on laboratory testing, oesophagitis on gastroscopy, diverticulitis on CT scan.) |  |

1. Please provide the following **measurements:**

Current weight: \_\_\_\_\_\_ kg Pre-diagnosis weight: \_\_\_\_\_\_ kg Height: \_\_\_\_\_\_ cm

1. Please select the most accurate description of any **dietary modification,** due to each condition *in isolation* (e.g. low FODMAP, gluten-free etc.)

| **Description** | Insert condition: | Insert condition: | Insert condition: |
| --- | --- | --- | --- |
| None. |  |  |  |
| **Minor** modification to diet (e.g. avoiding certain foods.) |  |  |  |
| Dietary modification **needed for control**. |  |  |  |
| Dietary modification produces **partial but incomplete control**. |  |  |  |

1. Please select the most accurate description of the **need for medication**,for each condition *in isolation.*

| **Description** | Insert condition: | Insert condition: | Insert condition: |
| --- | --- | --- | --- |
| None. |  |  |  |
| Medication **needed for control.** |  |  |  |
| Medication produces **partial but incomplete control.** |  |  |  |

1. Please select the most accurate description of any **alteration of bowel habit**,due to each condition *in isolation*.Consider both the frequency of bowel movement and form of stool.

| **Description** | Insert condition: | Insert condition: | Insert condition: |
| --- | --- | --- | --- |
| None. |  |  |  |
| **Disturbed** bowel habit (i.e. a change from pre-existing pattern). |  |  |  |
| **Severe persistent** disturbance of bowel habit. |  |  |  |

1. Please select the most accurate description of any **faecal incontinence**, due to each condition *in isolation.*

| **Description** | Insert condition: | Insert condition: | Insert condition: |
| --- | --- | --- | --- |
| None. |  |  |  |
| **Mild** incontinence of flatus or liquid stool. |  |  |  |
| **Partial** faecalincontinence. |  |  |  |
| **Complete** faecal incontinence. |  |  |  |

1. Please select the most accurate description of any **limitation of activity,** due to each condition *in isolation***.** Consider impact on occupation, hobbies, community and domestic ADLs etc.

| **Description** | Insert condition: | Insert condition: | Insert condition: |
| --- | --- | --- | --- |
| None. |  |  |  |
| **Minor.** |  |  |  |
| **Moderate.** |  |  |  |
| **Severe.** |  |  |  |

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

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