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| --- | --- | --- | --- | --- | --- | --- |
| Australian Government crest, Department of Veterans' Affairs branding | Upper Urinary Tract  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. | | | | | | | |

**Please provide a copy of the most recent renal function test**. If creatinine clearance has been formally measured, please ensure this is included.

1. Please select the most accurate description of **renal function**. If the veteran has more than one condition affecting renal function, please estimate the likely renal function, due to each condition *in isolation.*

| **Creatinine clearance** | **eGFR** | Insert condition: | Insert condition: | Insert condition: |
| --- | --- | --- | --- | --- |
| Normal renal function | |  |  |  |
| > 89 litres/day | > 62mL/min |  |  |  |
| 75 to 89 litres/day | 52 to 62 mL/min |  |  |  |
| 60 to 74 litres/day | 42 to 51 mL/min |  |  |  |
| 50 to 59 litres/day | 35 to 41 mL/min |  |  |  |
| 40 to 49 litres/day | 28 to 34 mL/min |  |  |  |
| < 40 litres/day | < 28mL/min |  |  |  |

1. Please select the most accurate description of any need for **treatment** of **symptoms and signs**, due to each condition *in isolation.*

| **Description** | Insert condition | Insert condition: | Insert condition: |
| --- | --- | --- | --- |
| None. |  |  |  |
| **Intermittent**. |  |  |  |
| **Continuous** medical treatment necessary. |  |  |  |
| **Incompletely controlled** by surgical or continuous medical treatment. |  |  |  |

1. Has the veteran undergone a **nephrectomy**? Yes No
2. Is the veteran receiving **peritoneal dialysis** or **haemodialysis**? Yes No

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