Please read this before you start

The Disability Allowance is available for reimbursement of additional costs arising from a Disability where the following criteria is met:

1. The person has a disability which is likely to continue for not less than six months; and
2. The disability has resulted in a reduction of the person's independent function to the extent that:
   - The person requires ongoing support to undertake the normal functions of life, or
   - The person requires ongoing supervision or treatment by a registered health professional.

For the purposes of qualifying for Disability Allowance, a disability means:

- physical disability or impairment
- physical illness
- psychiatric illness
- intellectual or psychological disability or impairment
- any other loss or abnormality of psychological, physiological, or anatomical structure or function (including sensory impairment)
- reliance on a guide dog, wheelchair, or other remedial means
- the presence of the body of organisms capable of causing illness.

For more information about Disability Allowance, refer to the "Guide for Medical Practitioners - Disability Allowance" brochure.

Name

1. What is the client's name:
   First name(s)
   
   Surname or family name

Disability details

2. Registered medical practitioner's name and address:

3. Does the person have a disability that meets the Disability Allowance criteria?
   - Yes  
   - No

4. What is the nature of the person's disability?
   Please tick the major disabilities or specify below:
   
   Psychological or psychiatric conditions
   - Stress (160)
   - Depression (161)
   - Bipolar disorder (162)
   - Schizophrenia (163)
   - Other psychological/psychiatric (165)

   Cardio-vascular disorders
   - Heart disease (130)
   - Stroke (131)
   - Other cardio-vascular (132)

   Immune system disorders
   - HIV / Aids (140)
   - Other immune system disorders (141)

   Nervous system disorders
   - Epilepsy (120)
   - Multiple sclerosis (121)
   - Parkinson's disease (122)
   - Muscular dystrophy (123)
   - Other nervous system disorders (124)

   Metabolic and endocrine disorders
   - Diabetes (150)
   - Other metabolic or endocrine disorders (151)

continued overleaf...
<table>
<thead>
<tr>
<th>Substance Abuse</th>
<th></th>
<th>Other disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol (170)</td>
<td></td>
<td>Overuse injury (RSI) (156)</td>
</tr>
<tr>
<td>Drug (171)</td>
<td></td>
<td>Complications of medical or surgical care (197)</td>
</tr>
<tr>
<td>Other substance abuse (172)</td>
<td></td>
<td>Other injury (198)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sensory disorders</th>
<th></th>
<th>Other disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blindness (180)</td>
<td></td>
<td>Congenital conditions (103)</td>
</tr>
<tr>
<td>Other visual / eye (181)</td>
<td></td>
<td>Intellectual disability (164)</td>
</tr>
<tr>
<td>Hearing / ear (182)</td>
<td></td>
<td>Cancer (102)</td>
</tr>
<tr>
<td>Other sensory disorders (183)</td>
<td></td>
<td>Infectious / parasitic diseases (105)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accident</th>
<th></th>
<th>Other disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burns (190)</td>
<td></td>
<td>Congenital conditions (103)</td>
</tr>
<tr>
<td>Fractures, dislocations, soft tissue injury (191)</td>
<td></td>
<td>Intellectual disability (164)</td>
</tr>
<tr>
<td>Poisoning, toxic effects (192)</td>
<td></td>
<td>Cancer (102)</td>
</tr>
<tr>
<td>Internal injuries (193)</td>
<td></td>
<td>Infectious / parasitic diseases (105)</td>
</tr>
<tr>
<td>Injury to the nervous system (194)</td>
<td></td>
<td>Respiratory disorders (107)</td>
</tr>
<tr>
<td>Back pain / injury (195)</td>
<td></td>
<td>Genito-urinary disorders (108)</td>
</tr>
</tbody>
</table>

5. Please indicate the expected duration of the disability:
- Less than 6 months
- 6 to 12 months
- 1 to 2 years
- 2 to 3 years
- Permanent

Verification of doctor or specialist visits

6. Please list the type, cost and how often visits to doctors or specialists are necessary and result from the stated disability:

<table>
<thead>
<tr>
<th>Type of consultation</th>
<th>Cost</th>
<th>How often (eg daily, weekly, monthly)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CP</td>
<td>$10-32</td>
<td>2 monthly</td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

Items / services / treatments / pharmaceuticals

7. Please list the pharmaceuticals, items, services or treatments that are necessary and of therapeutic value for the stated disability:

- Prescriptions
- Water filters
- Transport
- Dietary supplements
- Garden costs
- Phone

Registered Medical Practitioner's verification

Please print or stamp your full name, address, telephone number and Medical Council registration number.

Registered Medical Practitioner’s stamp or name and address

Medical Council registration number

Ph  Fax

Medical Practitioner’s signature

Day  Month  Year

This information is required under the Social Security Act 1964.

Privacy Act: The person has been advised and understands that this information is required for benefit assessment purposes.