INITIAL Medical Certificate for ASBESTOS-RELATED DISEASES Compensation

(To be completed by relevant Medical Specialist only)

Asbestos-Related Diseases (Occupational Exposure) Compensation Act 2011

The Asbestos Compensation Commissioner is the compensation provider for Tasmanian workers that have contracted an asbestos-related disease through their employment in Tasmania.

Please complete all relevant sections of the form. 'As previous' or 'Unchanged' is not considered sufficient information. Where the worker has completed an authority for the release of medical information, please send all relevant test results, scans and reports to the Asbestos Compensation Commissioner, by electronic means where possible (acc@justice.tas.gov.au). This will assist with processing the worker's claim in a timely manner.

WORKER'S DETAILS

Title (Mr/Ms/Miss/Other) ____ Last name ____

Given name(s) ____

Date of birth ____

Postal address ____

____ Postcode ____

Telephone numbers Home ____ Work ____

Mobile ____

MEDICAL CERTIFICATION

I examined the patient on

Current clinical symptoms

Diagnosis of the asbestos-related disease is:

Based on the patient history, in my opinion the disease is:

- ○ reasonably attributable to workplace exposure (state reasons)

- ○ or other cause (state reasons)

If known, is the disease a new disease/condition.

○ YES ○ NO Provide details

Past history of similar diseases/conditions or comments relevant to disease/condition

I am of the opinion that the patient is:

- ○ not reasonably likely to die within 2 years from the date on which this certificate is given (non-imminently fatal asbestos-related disease)
- ○ reasonably likely to die within 2 years from the date on which this certificate is given, but the asbestos-related disease is not likely to be a significant factor contributing to the worker's death (non-imminently fatal asbestos-related disease)
- ○ reasonably likely to die within 2 years from the date this certificate is given and the asbestos-related disease is reasonably likely to be a significant factor contributing to the workers' death (imminently fatal asbestos-related disease).

Provide full details of any other medical condition/s that may contribute to the person's death (if applicable)

INCAPACITY / FITNESS FOR WORK (complete where relevant)

The patient is currently:

- ◯ fit to continue duties
- ◯ fit to return to duties from ______
- ◯ fit for modified duties, with limitations specified below, from ______ to ______ (max. 12 months on this certificate)
- ◯ already retired from employment

Restrictions

______

______

- ◯ totally unfit for work from ______ to ______ (max. 12 months on this certificate) due to:

(Please specify reasons for incapacity)

______

______

______

______

- ◯ The patient has wholly/substantially recovered from the effects of the asbestos-related disease
- ◯ The patient's incapacity is no longer due wholly/substantially to the asbestos-related disease.

(Please specify grounds for opinion)

______

______

______

______

Provide test results, xrays, scans, and/or examinations conducted upon which the diagnosis and/or findings of causation are based. These must be recent images (i.e. within 6 months).

______

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In addition, for non-malignant cases, provide full lung function testing including spirometry **and** gas transfer results.

CURRENT MEDICAL TREATMENT SUMMARY (treating medical specialist or doctor to complete)

What type of medical treatment or pharmaceutical treatment is currently required for this disease?

TREATMENT TYPE	BENEFITS OF TREATMENT	DATE OF REVIEW	NUMBER OF SESSIONS

Provide details of any other medical services, nursing services, hospital services, rehabilitation services, ambulance services, constant attendance services, physiotherapy services or psychological services required for the treatment of the disease, include expected duration of treatment where applicable.

Has the patient been referred to another health/medical professional? If yes, provide details.

Has the patient consulted other health/medical professionals? If yes, provide details.

MEDICAL PRACTITIONER DETAILS

Name and address of registered medical practitioner (please print)

Name

Postal address

Postcode

Phone

Fax

Qualifications

Specialty

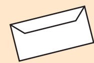
Occupation

Provider number

Signature

Date

SUBMIT COMPLETED FORM



BY post to:
The Asbestos Compensation Commissioner
PO Box 56
ROSNY PARK TAS 7018

OFFICE USE ONLY

Actioned ______ Initials ______ Date ______