*This example report template was created to assist medical professionals to gather relevant information for the Disability Support Pension. It provides guidance on what type of evidence Centrelink uses to assess whether a person is eligible. We have tried to keep the template as short as possible, however, our experience shows it is in the applicant’s best interest to have comprehensive information included. It is likely to take between 15 to 45 minutes to complete this form. Medicare can cover the cost of this appointment. You are not required to provide evidence in this report format. It is not guaranteed that providing evidence in this format will result in a person being found eligible for the DSP. If using this template, please delete all sections marked in red.*

Date:

To Whom It May Concern,

**Re: Letter in support of DSP**

I am assisting person’s name with their application for the Disability Support Pension. This person has been a patient at this practice since …../…../……….

My details are:

Name:

Qualifications:

Address:

Phone Number:

1. **Diagnosis**
	1. Please list the main impairments and the following information:

|  |  |  |  |
| --- | --- | --- | --- |
| Diagnosis | Date of Diagnosis  | Diagnosis Made By | Is it likely to be permanent? Y/N |
|  |  |  |  |
| Diagnosis | Date of Diagnosis  | Diagnosis Made By | Is it likely to be permanent? Y/N |
|  |  |  |  |

Please attach any supporting evidence relating to the diagnosis

1.2 Please identify which of the following categories apply:

[ ] Intellectual Disability [ ] Physical Disability

[ ] Cognitive Disability [ ] Psychiatric/Psychosocial Disability

[ ] Neurological Disability [ ] Developmental Delay

[ ] Sensory Disability

1.3 In the next two years and/or foreseeable future the functional capacity is:

[ ]  Going to, or is likely to, stay the same.

[ ]  Going to, or is likely to, improve.

[ ]  Going to, or is likely to, worsen.

1.4 A brief description of treatment includes:

|  |  |  |
| --- | --- | --- |
| Condition | Treatment | Outcome |
|  |  |  |

**Past Treatment and Outcomes** (*list previous medications, aids, protective equipment, and assistive technology)*

**Current Treatment** (*list current medication, aids and protective equipment and if these are expected to improve the symptoms or if they are for maintenance only)*

|  |  |  |
| --- | --- | --- |
| Condition | Treatment | Expected Outcome |
|  |  |  |

**Other Treatment Options**

Please list other treatment options not trialled and or considered. State the reason (*eg medication interaction, impact of other impairments, affordability)*

|  |  |
| --- | --- |
| Other Treatment Options | Reasons  |
|  |  |

Functional Impact

It is my professional opinion that person’s name should score (insert value) points under the Impairment Table for (insert impairment Table(s) used).

Person’s name symptoms and functional impacts include:

* Copy the relevant functional impairment with “yes” or “no” next to each criteria.

If you require clarification to any of the information stated above, please do not hesitate to contact me.

Kind Regards,

Your name and signature