MEDICAL ASSESSMENT FORM (FORM B) - GUIDELINES FOR MEDICAL PRACTITIONERS

The Personal Injuries Assessment Board is an independent statutory body. Our objective is to ensure that people claiming for injuries sustained in an accident, have their compensation assessed quickly and fairly and without unnecessary litigation overheads. The claimant must submit a report from their treating medical practitioner for us to assess their claim. Please note a copy of the medical report will be passed to the respondent/s (the person/s against whom the claim is being made) and their insurers where known, in order that they may know the nature and extent of the claim. As a result the medical report should only contain medical history relevant to the claim being made. We have undertaken to have the majority of claims assessed within nine months of submission and with this time frame in mind, it is vital that your report adheres to the following guidelines; is clear, concise and gives, as far as possible, a final prognosis and likely recovery period.

Reports should

- ✓ be submitted in a standard format as per the attached template (ideally typed but in block capitals / easily legible at a minimum)
- ✓ be as clear and concise as possible
- ✓ contain an opinion/prognosis and your view on the likely recovery time for the claimant's injuries to resolve. If a full recovery is unlikely, outline the residual symptoms likely to be suffered by the claimant and what effect these will have on their lifestyle/work
- ✓ include relevant details of the claimant's medical and accident history and advise whether the accident has exacerbated any pre-existing symptoms/injury
- ✓ only include medical history/information relating to the claimant (and not about any third party)
- ✓ include good quality photographs where appropriate or requested

Where a final prognosis is not currently available we may arrange a further up to date examination of the claimant. If the claim proceeds to assessment, the claimant may be awarded the reasonable and necessary cost of this medical report. Failure to furnish an adequate report may result in exceptional cases, in this amount not being awarded in full or at all.

MEDICAL ASSESSMENT FORM (FORM B)

Application number (if available)

Claimant name		
Address		
Gender		
Marital status		
Date of birth		
Occupation		
Currently at work	Yes ☐	No ☐
Height		
Weight		
R/L hand dominant		

Date of accident	
Date of examination	

Brief details of the accident/incident

Injuries sustained including diagnostic information

Date treatment first sought	
From whom was treatment received?	
Was patient hospitalised	
Where was patient hospitalised	
Period of hospitalisation	
Length of absence from work	
If absence is on-going is it due to the accident?	
Was/is the claimant's absence period reasonable	
Number of GP visits	
Number of specialists visits, if any	
Identity of specialists, if any	

Treatment/investigations to date	
Number of physiotherapy sessions, if any	

WHO International classification of diseases (ICD)

Relevant medical history (including previous and subsequent accidents and clarification on any interaction of injuries)

Aggravation of pre-existing condition?	Yes	☐	No	☐
If yes please give nature of pre-existing condition				
Give details of previous accident history, if any				
Was pre-existing condition symptomatic before accident?				

Present complaints

Clinical findings on examination (please include photographs if appropriate or requested)

Clinical description of effects on claimant's illness/disablement – practitioners should indicate the degree, if any, to which the claimant's condition is currently affecting his/her ability in the following

	Normal	Mild	Moderate	Severe	Profound
Mental health	☐	☐	☐	☐	☐
Learning/intelligence	☐	☐	☐	☐	☐
Consciousness/seizures	☐	☐	☐	☐	☐
Balance/co-ordination	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Speech	☐	☐	☐	☐	☐
Continence	☐	☐	☐	☐	☐
Reaching	☐	☐	☐	☐	☐
Manual dexterity	☐	☐	☐	☐	☐
Lifting/carrying	☐	☐	☐	☐	☐
Bending/squatting	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐

Anticipated treatment required into the future to include approximate costs

Opinion/comment/latest prognosis

Are the injuries consistent with the accident? If not please specify
Are further investigations required? If so please specify
Is a full recovery expected? If not please detail likely effects on lifestyle/work
Please state the expected time period to full recovery (from the date of accident)
Are late complications expected? If so please specify
Are further specialist reports recommended? If so please specify

General comments and observations

Completed by:

Practitioner signature and name:
Address:
Qualifications:
Date of completion: