

PIAB 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. 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.

PIAB Medical Assessment Form (Form B)

Claimant Name	
Address	
Gender	
Marital Status	
Date of Birth	
Occupation	
Currently at Work	
Height	
Weight	
R/L Hand Dominant	
Date of Accident	
Examination date	
Previous examination information	
Time elapsed since date of accident (accident date to examination date)	Years Months

Brief details of the accident/incident

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Injuries Sustained (including diagnostic information)

Details (include history of condition immediately after accident and in subsequent few days)

Summary Diagnostic Information

Date first Treatment Sought	
From whom was it received	
Was patient hospitalised?	
If yes, where was patient hospitalised?	
Duration of inpatient stay?	
Length of absence from Work	From To
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 Physiotherapy sessions	
Number of Specialist/s visits	
Identity of Specialist/s, if known	

Treatment / Investigations to date

Medications / dosage / changes in e.g. last six months.

Number of physiotherapy sessions, if any

WHO International classification of diseases (ICD)

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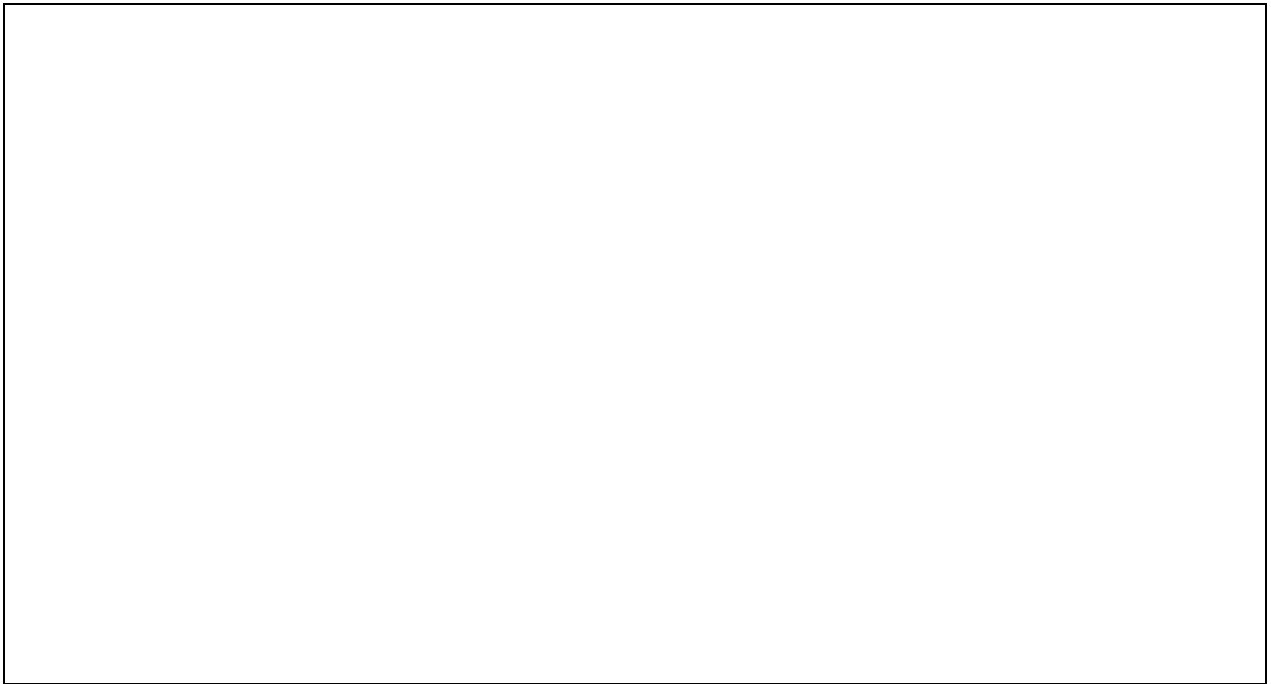
Relevant Medical History (including previous and subsequent accidents and clarification on any interaction of injuries)

Nil relevant	
Aggravation of pre-existing condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes please give nature of pre-existing condition	
Give details of previous accident history, if any	
Was pre-existing condition active / symptomatic before the accident?	

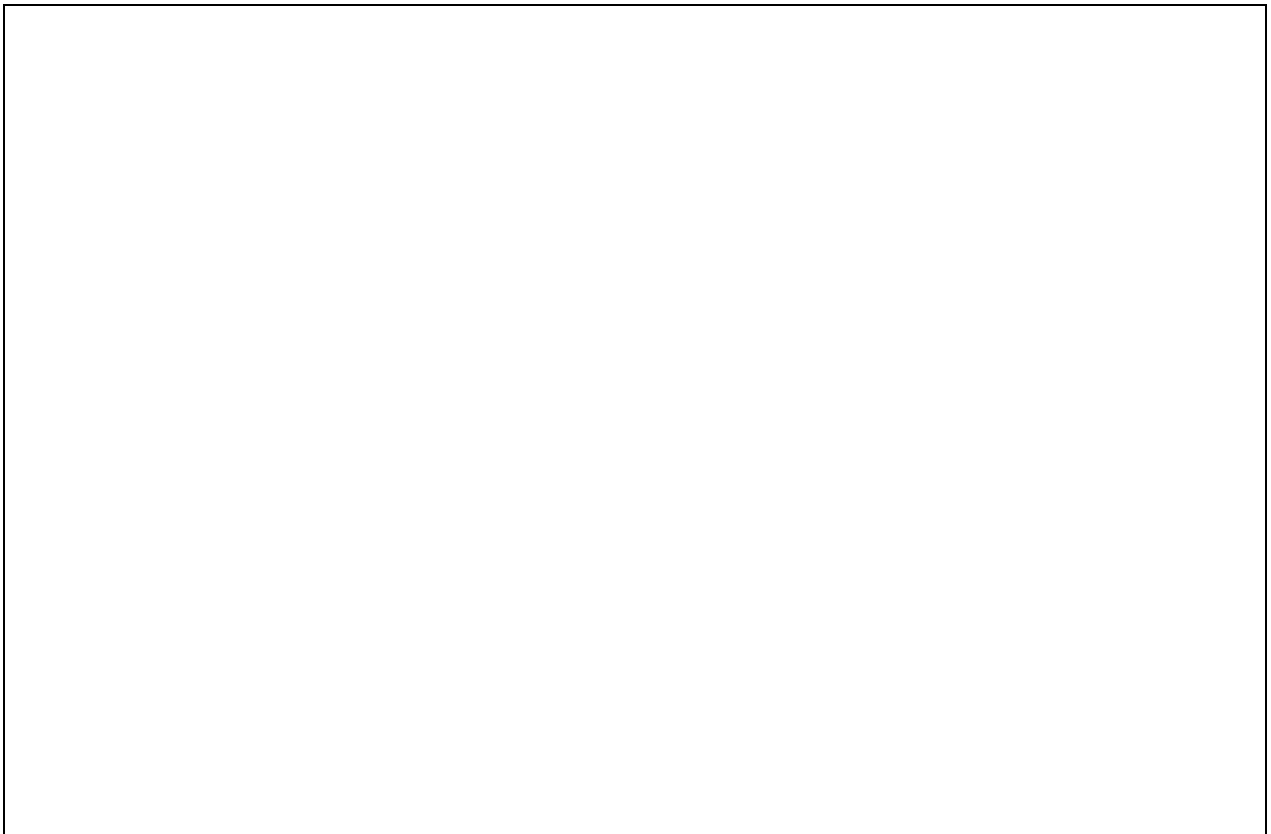
Lifestyle Effects

Occupational	
Recreational	
Domestic / Personal	

Present Complaints (to include effects on recreational activities etc.)

A large, empty rectangular box with a thin black border, intended for the patient to describe their present complaints and any effects on recreational activities.

Clinical Findings on Examination (please include photographs if appropriate or required)

A large, empty rectangular box with a thin black border, intended for the patient to describe their clinical findings on examination, including any photographs if appropriate or required.

Please Complete This Section Where Injury is Neck Pain or Whiplash Associated Disorder

Assessment of cervical range of motion – Normal Abnormal

Palpation for consistent tenderness – Present Absent

Neurological Signs - Present Absent

Treatment/Investigations to date -

The claimant should complete the attached NDI Questionnaire – Neck Disability Index

NDI Score = %

Following Assessment claimants should be classified according to the Quebec Task Force (QTF) Classification of Grades

Indicate the Whiplash Associated Disorder (WAD) Grade

WAD 0 (No neck pain, stiffness or any physical signs are noticed)

WADI (Neck complaints of pain, stiffness/but no physical signs)

WAD II (Neck complaints and decreased range of motion and local tenderness in the neck)

WAD III (Neck complaints plus neurological signs)

WAD IV (Neck complaints and fracture, dislocation or injury to the spinal cord)

If the claimant's WAD Grade has changed during the course of their recovery, please comment on same:

Indicate the degree to which you feel the claimant's symptoms / disability have been caused by the accident / event which is the subject of this claim? Tick one box

Based on my assessment of the injury as described by the Claimant the accident/events accounts for

1. none of the symptoms / disability
2. a small proportion ($\leq 25\%$) of the symptoms / disability
3. a moderate proportion (50%) of the symptoms / disability
4. most ($\geq 75\%$) of the symptoms / disability
5. all of the symptoms / disability

Clinical Description of effects of Claimant's Illness / Accident / 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning/Intelligence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consciousness/Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance/Co-ordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manual Dexterity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending/ Lifting/Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Anticipated treatment required into the future to include appropriate costs

Opinion/Comment/Latest Prognosis

Indicate the degree to which you feel the claimant's symptoms / disability have been caused by the accident / event which is the subject of this claim? Tick one box

Based on my assessment of the injury as described by the Claimant the accident/events accounts for

1. none of the symptoms / disability
2. a small proportion ($\leq 25\%$) of the symptoms / disability
3. a moderate proportion (50%) of the symptoms / disability
4. most ($\geq 75\%$) of the symptoms / disability
5. all of the symptoms / disability

<p>Are further investigations required?</p> <p>Have all reasonable steps been taken to alleviate remaining symptoms / disability. If no, please elaborate</p>	
<p>Is a full recovery expected?</p> <p>If not please detail likely effects on lifestyle / work</p>	
<p>Estimated time period to full recovery (from the date of the accident)</p>	
<p>Are late complications expected?</p>	
<p>Are further Specialist reports recommended?</p> <p>If so please specify</p>	

General Comments and Observations

Additional Information

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Completed by

(It is the duty of the completing expert to assist the Court as to matters within his or her field of expertise. This duty overrides any obligation to any party paying the fee of the expert).

Name	
Signature	
Address:	
Qualifications:	
Completion Date:	

Neck Disability Index (NDI developed by: Vernon, H. & Mior, S. (1991). *The Neck Disability Index: A study of reliability and validity. Journal of Manipulative and Physiological Therapeutics. 14, 409-415*)

Claimant name	
PIAB reference	
Date of assessment	

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and **mark in each section only the one box that applies to you**. We realise you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Section 1: Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but can manage most of my personal care
- I need help every day in most aspects of self care
- I do not get dressed, I wash with difficulty and stay in bed

Section 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

Section 4: Reading

- I can read as much as I want to with no pain in my neck
- I can read as much as I want to with slight pain in my neck
- I can read as much as I want with moderate pain in my neck
- I can't read as much as I want because of moderate pain in my neck
- I can hardly read at all because of severe pain in my neck
- I cannot read at all

Section 5: Headaches

- I have no headaches at all
- I have slight headaches, which come infrequently
- I have moderate headaches, which come infrequently

- I have moderate headaches, which come frequently
- I have severe headaches, which come frequently
- I have headaches almost all the time

Section 6: Concentration

- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty in concentrating when I want to
- I have a lot of difficulty in concentrating when I want to
- I have a great deal of difficulty in concentrating when I want to
- I cannot concentrate at all

Section 7: Work

- I can do as much work as I want to
- I can only do my usual work, but no more
- I can do most of my usual work, but no more
- I cannot do my usual work
- I can hardly do any work at all
- I can't do any work at all

Section 8: Driving

- I can drive my car without any neck pain
- I can drive my car as long as I want with slight pain in my neck
- I can drive my car as long as I want with moderate pain in my neck
- I can't drive my car as long as I want because of moderate pain in my neck
- I can hardly drive at all because of severe pain in my neck
- I can't drive my car at all

Section 9: Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hr sleepless)
- My sleep is mildly disturbed (1-2 hrs sleepless)
- My sleep is moderately disturbed (2-3 hrs sleepless)
- My sleep is greatly disturbed (3-5 hrs sleepless)
- My sleep is completely disturbed (5-7 hrs sleepless)

Section 10: Recreation

- I am able to engage in all my recreation activities with no neck pain at all
- I am able to engage in all my recreation activities, with some pain in my neck
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- I am able to engage in a few of my usual recreation activities because of pain in my neck
- I can hardly do any recreation activities because of pain in my neck
- I can't do any recreation activities at all

Score: /50 Transform to percentage score x 100 = %points

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows: Example: 16 (total scored)
50 (total possible score) x 100 = 32%.

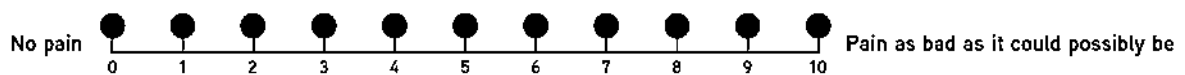
If one section is missed or not applicable the score is calculated: 16 (total scored)
45 (total possible score) x 100 = 35.5%.
Minimum Detectable Change (90% confidence): 5 points or 10 %points.

Claimant signature: _____ Date: _____

Visual Analogue Scale (VAS) for pain

Claimant name	
PIAB reference	
Date of assessment	

The VAS for pain consists of a 10cm line with two end-points representing 'no pain' and 'pain as bad as it could possibly be'. Patients with WAD are asked to rate their pain by placing a mark on the line corresponding to their current level of pain. The distance along the line from the 'no pain' marker is then measured with a ruler giving a pain score out of 10.



Claimant signature: _____ Date: _____