# NT12B

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# NORTHERN TERRITORY GOVERNMENT

# MEDICAL EXAMINATION REPORT FORM

###### MEDICAL INCAPACITY

**(Invalidity Retirement)**

## IN CONFIDENCE

**1**

**NOTES FOR THE APPROVED HEALTH PRACTITIONER**

The employee named in Section 2 has been requested to report for examination in order that an assessment can be made as to whether the employee is totally and permanently incapacitated. (An employee shall be taken to be totally and permanently incapacitated if, because of a physical or mental condition, it is unlikely that the employee will ever be able to work in any employment or hold office for which he or she is reasonably qualified by education, training and experience or could be so qualified after retraining). In particular, this medical examination is designed to obtain opinions on the likely long-term course of the employee’s illness or injury.

If you consider that the employee is not totally and permanently incapacitated, but is unfit to perform the duties of his or her current job, please make recommendations to the employer specifying strategies that may be implemented in order to facilitate the employee’s continuation of duty and send your report to the referring agency Contact Officer.

**Please ask the employee to complete the Authority to Exchange Medical Information at Attachment A.**

**When you have completed this form:**

* **If you consider that the employee is totally and permanently incapacitated - forward it and all supporting documents to the NT Medical Advisor, Northern Territory Superannuation Office, GPO Box 4675, Darwin NT 0801; or**
* **If you do not consider that the employee is totally and permanently incapacitated - forward it directly to the referring agency Contact Officer specified in section 2 below.**

**2**

**EMPLOYEE’S** **PERSONAL AND EMPLOYMENT DETAILS** **(to be completed by employer)**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Surname: | | Given Names: | | | | | Gender: | | Date of Birth: | | |
|  |  |  | | | |  |  |  |  | | |
|  | | | | | | | | | | | |
| Designation of Employee: | | |  | Employing Agency: | | | | | | | |
|  | | |  |  | | | | | | | |
|  | |  | | | | | | | | | |
| Employer Contact Officer: | | Telephone: | | | Superannuation Membership: | | | | | | |
|  |  |  | | | NTGPASS | | | | |  |  |
| CSS | | | | |  |  |
|  |  | | | PRIVATE SCHEME | | | | |  |  |
|  | | | | | | | | | | | |
| Address of Employing Agency: | | |  | Nature of Duties: | | | | | | | |
|  | | |  | * Job Description attached | | | | | |  |  |
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3

**SICK LEAVE DETAILS (to be completed by employer)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No |  | | | |
| Is the employee currently on sick leave? |  |  |  | Date on which sick leave commenced |  | |
|  | Yes | No |  |  | Yes | No |
| Medical/Work Reports and reports are attached |  |  |  | Has the employee applied for workers compensation benefits? |  |  |
|  | Yes | No |  | | Yes | No |
| Sick leave records over past 2 years are attached |  |  |  | Is the employee currently in receipt of workers compensation benefits? |  |  |
|  |  |  |  |

**4**

#### APPROVED HEALTH PRACTITIONER’S REPORT AND ASSESSMENT - Approved Health Practitioners must provide a typed report and assessment, addressing all of the following:

#### (Attach additional papers where necessary)

|  |  |  |  |
| --- | --- | --- | --- |
| * Current complaint / diagnosis | | | |
|  | | | |
| * History (both occupational and medical) | | | |
|  | | | |
| * Clinical findings | | | |
|  | | | |
| * Assessment (including review of reports / social factors / discussions with agency staff). Please identify any inconsistencies. | | | |
|  | | | | |
| After clinical examination, medical tests, specialist tests and any other tests as appropriate,  I consider that the employee is suffering from the following medical condition(s):  \*(Where there is an incapacity for work please give the estimated percentage each medical condition contributes to the incapacity. If the condition does not contribute please show zero). | | | | |
|  | Condition | |  | Percentage\* |
| 1. |  | |  | % |
|  |  | |  |  |
| 2. |  | |  | % |
|  |  | |  |  |
| 3. |  | |  | % |
|  |  | |  |  |
| 4. |  | |  | % |
|  |  | |  |  |
| 5. |  | |  | % |
|  |  | |  |  |
| 6. |  | |  | % |

**APPROVED HEALTH PRACTITIONER’S RECOMMENDATIONS**

**5**

The recommendations made below must be supported by reasons in the body of the report.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | Do you consider that the employee is totally and permanently incapacitated? | |  |  | NO |  | YES |
|  | | | | | | | |
| 2. | Is the employee medically fit to resume all duties of his/her current position? | |  |  | NO |  | YES |
|  |  | | | | | | |
| 3. | Is a further period of sick leave recommended? | |  |  | NO |  | YES |
|  | If YES, | (a) To what date should further sick leave be granted? |  | | | |
| (b) Is there any treatment/rehabilitation program the employee should be undertaking while on sick leave? |  | | | | |
|  | | | | |
|  | | | | | | | |
| 4. | Is the employee able to perform modified duties or reduced hours in his/her current position? | |  |  | NO |  | YES |
|  | If YES, | (a) What modification to current duties do you recommend? |  | | | | |
| (b) For how long are modified duties required? |  | | | | |
| (c) Specify recommended hours of duty and the period. |  | | | | |
| (d) Would the employee benefit from intervention, strategies eg occupational therapy, counselling? |  | | | | |
|  | | | | | | | |
| 5. | Is there evidence that the employee’s incapacity is due to willful action on the part of the employee. | |  |  | NO |  | YES |
|  |  | |  |  |  |  |  |
| 6. | Do you have any other comments or recommendations (eg a further review)? | |  |  | NO |  | YES |
|  | If YES, please provide comments or recommendations. | | | | | | |
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|  | | | | | | | |
| 7. | Is the employee’ medical condition of a terminal nature such that life expectancy is less than 24 months? | |  |  | NO |  | YES |
|

**SIGNATURE OF APPROVED HEALTH PRACTITIONER**

**6**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I authorise the release of this report to the employee’s general Health practitioner or treating specialist if so requested. | | | | |
|  | | | | |
|  |  | NO |  | YES |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Approved Health Practitioner’s Name: |  | Location: | | |  | | | |
|  |  |  | | |  | | | |
| Signature: |  | Date: | | |  | | |
|  | | | | | | | | |
| **All accompanying documents provided by the agency** | | | | | | | | |
| **(medical / work reports) are attached.** | | |  | NO | |  | YES | |
| **If the employee is considered totally and permanently incapacitated please forward all documents to the NT Medical Advisor, Northern Territory Superannuation Office, GPO Box 4675 Darwin, NT 0801.**  **If the employee is not considered totally and permanently incapacitated - forward it directly to the referring agency Contact Officer specified in section 2.** | | | | | | | | |

**7**

**RECOMMENDATION OF NT MEDICAL ADVISOR**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | AGREE |  | DISAGREE WITH THE RECOMMENDATION OF THE APPROVED HEALTH PRACTITIONER | | | |
| Comments: |  | | | | | | |
|  | | | | | | | |
|  | | | |  |  | |
| NT Medical Advisor | | | |  | | Date |

PRINT NAME:

**NT12B: ATTACHMENT A**

##### DECLARATION TO AUTHORISE THE EXCHANGE OF MEDICAL INFORMATION

I declare that I, the employee, have read the Employee Information Sheet and understand the purpose of the examination and uses that may be made of the report and;

I also declare that if, as a consequence of this examination, the Approved Health Practitioner and / or the NT Medical Advisor requires further medical information from any doctor, hospital or clinic, I give permission for the exchange of any relevant medical information.

I also understand that this report may be required for superannuation purposes and authorise release of this report and any other relevant medical information to the Commissioner of Superannuation or the Commonwealth Superannuation Scheme Board.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | |  | |
| Signature of Employee  PRINT NAME: |  | | Date | |
| In addition, please list all **Doctors, Hospitals or Clinics** visited in the past 2 years. | | | | |
| Name | | **Reason** | | **Date of consultation** |
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**NT12B: ATTACHMENT B**

###### MEDICAL EXAMINATION INFORMATION SHEET

## IMPORTANT INFORMATION FOR EMPLOYEES

**APPOINTMENT DETAILS**

Surname:

Given Names:

You are requested to report for a medical examination as follows:

Date:

Time:

Place:

Name of Approved Health Practitioner:

**PLEASE READ THIS INFORMATION CAREFULLY.**

The purpose of this medical examination is to enable the Approved Health Practitioner to:

* assess your current health and status; and
* obtain an opinion on whether you are permanently and totally incapacitated and should be retired from the Northern Territory Public Sector on grounds of total and permanent medical incapacity.

You should attend for the medical examination at the time and place specified.

**If you are unable to attend at this time / place, please contact (Name) on telephone (number) immediately.**

Employees should be aware that the failure to attend a medical examination as directed could result in disciplinary action being taken.

You are encouraged to submit supporting evidence to the Approved Health Practitioner conducting the examination. The list in Attachment C may be used to assist your general practitioner in providing this information.

At the medical examination you will be asked to sign a declaration that you have read this information sheet and that you have given permission to exchange medical information.

The Medical Examination Report will be sent directly to the referring agency Contact Officer, unless you have been assessed as totally and permanently incapacitated, or there is a conflict or medical opinion or your CEO requests otherwise. In these situations your medical examination report will be sent to the NT Medical Advisor for review. The assessment is then forwarded to the Chief Executive Officer of the requesting agency.

Information from this examination will be used by your Chief Executive Officer to assist in deciding your employment status. Information may also be provided to your superannuation scheme to assess your superannuation benefits.

Invalidity retirement will only be considered if the employee is essentially totally and permanently incapacitated. It will normally only be granted after careful examination and where there is certainty that the individual has become totally and permanently incapacitated.

**NOTE: Payment of an invalidity retirement benefit is not automatic and it is important that if you are a member of a private superannuation scheme you contact the fund manager to discuss your eligibility to any entitlements.**

**NT12B: ATTACHMENT C**

# BELOW IS A LIST OF POINTS THAT MAY BE ADDRESSED BY YOUR GENERAL PRACTITIONER OR SPECIALIST IN A REPORT TO THE APPROVED HEALTH PRACTITIONER

It is important that the evidence provided is as comprehensive and current as possible, to assist the Approved Health Practitioner undertaking the assessment.

The medical evidence should provide:

History of the employee’s illness or accident or medical condition.

* Current symptoms
* as described by the employee
* as observed by their general practitioner or specialist at presentation
* Diagnosis
* indicate the severity of the condition
* is it transitory or long term
* Treatment
* current medications/physical therapy/psychotherapy and their results
* results of relevant testing conducted or comments regarding those tests
* description of any additional treatment which would assist in alleviating the condition
* Prognosis

The effect of the condition on the employee’s ability to work:

* could the employee be rehabilitated back to his/her former position or its equivalent?
* could the employee work modified duties or reduced hours?
* could the employee be retrained for any other position ?
* Terminal conditions
* Life expectancy in months eg “less than three months”
* will the employee require assistance with personal or nursing care on a daily basis within the next two years?

**NT12B: ATTACHMENT D**

**MEDICAL EXAMINATION INFORMATION SHEET**

## IMPORTANT INFORMATION FOR EMPLOYERS

**PLEASE READ THE FOLLOWING CAREFULLY:**

This medical examination must be undertaken by an Approved Health Practitioner who is not the employee’s treating practitioner. The employer should complete the appointment details on the Employee’s Information Sheet and the details in Sections 2 and 3 of the Medical Examination Report Form.

If the Approved Health Practitioner prefers, the Medical Examination Report Form could be sent to them by email.

The employer should attach *copies* of relevant reports, including details of:

* current duties,
* health assessment reports,
* details of any rehabilitation program undertaken.

Incomplete reports may result in delays in the assessment of the employee.

It may also be useful to attach supplementary details which explain the job parameters and physical requirements in addition to the Job Description, which would more clearly indicate the employees work environment and job requirements such as:

**Physical requirements**

stature: standing, sitting

driving: exertion, lifting and carrying

mobility: stairs, ladders, climbing, walking

**Location**

predominately outdoors or indoors

**Personal Contacts**

counter/client: public contact / peer group

internal: management/subordinate

confrontation: welfare

**Complexity**

Stressful, argumentative, pressure to meet deadlines/targets

**NOTE: It is important that the information provided is as comprehensive and current as possible to assist the Approved Health Practitioner in reaching a considered and fair conclusion. It is strongly recommended that the employer contact the Approved Health Practitioner to discuss their concerns regarding the employee and their reasons for the referral as well as providing written information.**

If the Approved Health Practitioner finds the employee to be totally and permanently incapacitated, (or there is a conflict of medical opinion or the CEO has requested otherwise) the Medical Examination Report will be forwarded to the NT Medical Advisor to review the Approved Health Practitioner’s assessment. The assessment is then forwarded to the Chief Executive Officer of the requesting agency.

In the cases where the Approved Health Practitioner has not determined the employee to be totally and permanently incapacitated the Medical Examination Report will be directly to the referring agency Contact Officer.

**NOTE: If the employee is a member of a private superannuation scheme the payment of invalidity retirement benefits is not automatic. It is important that the employee contact their fund manager to discuss their entitlement and what if any information should be provided by the agency.**

If the employee is in receipt of workers compensation benefits or has made an application for workers compensation benefits this should be clearly stated in the information provided to the Approved Health Practitioner**. It is important that the Gallagher Bassett or other private insurers have been advised of the intention to refer the employee for the medical examination and that they concur with this action.**