

**CONTINUING DISABILITY STATEMENT (CDS)**  
CLAIMANT STATEMENT – ALL QUESTIONS MUST BE ANSWERED

CLAIMANT DETAILS	(PLEASE PRINT)	Claim Number: .....
Full Name: .....		Treating Doctor: .....
Postal Address: .....		Contact Phone ( ) .....
Suburb: .....	State: ..... P/Code: .....	DOB: ...../...../.....

1. What condition is **currently** preventing you from performing work related duties? .....
2. What treatment are you currently undertaking for the above reported condition(s)? (please tick)

<u>1.</u> Physiotherapy <input type="checkbox"/>	<u>2.</u> Hydrotherapy <input type="checkbox"/>	<u>3.</u> Chemotherapy <input type="checkbox"/>	<u>4.</u> Radiotherapy <input type="checkbox"/>
<u>5.</u> Gym based exercise <input type="checkbox"/>	..... Days per week	Supervised <input type="checkbox"/>	Unsupervised <input type="checkbox"/>
<u>6.</u> Alternative therapy			
<u>7.</u> Surgery (Date)			
<u>8.</u> Medications (list)			
<u>9.</u> Other (Please specify)			

Review Dates with Doctor's		Next Review Date
General Practitioner		
Specialist(s)		

3. What improvements have you made in the past 4-6 weeks? .....

4. Has anything happened to prolong recovery of your condition? Y  N   
If yes, please explain.....

5. In your own words please describe what activities you are able to perform: (include work and home duties)

6. What is your current employment status?  
Employed  Resigned  Terminated  Other .....

7. Are you currently fit to perform light duties at work? Yes  No   
*(If yes, please ask your doctor to fill in only the Partial Incapacity Section)*

8. If No, when do you estimate you will be fit for?

Suitable/Alternate Duties	< 1 Month <input type="checkbox"/>	1-2 Months <input type="checkbox"/>	2-6 Months <input type="checkbox"/>	6-12 Months <input type="checkbox"/>	12+ Months <input type="checkbox"/>
Full Duties	< 1 Month <input type="checkbox"/>	1-2 Months <input type="checkbox"/>	2-6 Months <input type="checkbox"/>	6-12 Months <input type="checkbox"/>	12+ Months <input type="checkbox"/>

9. Have you received any payment from any other sources during your disability? Yes  No   
If yes, please provide details: .....

**All information that I/we have given in this statement is true and correct**

Name (Print): .....

Signature: ..... Date: ..... / ..... / .....

**STATEMENT OF DISABILITY**  
**ATTENDING PHYSICIANS STATEMENT**

Page 1 of 2

Please ensure work capacity details are completed and the form is signed on page 2

Patient's Name: .....

DOB: ..... / ..... /.....

**Patient's Condition**

1. What is the condition **currently** disabling your patient? .....

.....

.....

**Treatment**

2. What treatment has your patient undergone in the past 4-6 weeks? .....

.....

.....

3. Are you proposing further treatment, different from the above, and if so, what treatment is it? .....

.....

.....

4. To the best of your knowledge, is your patient compliant with the prescribed treatment? Yes  No

**Medical Status**

5. Has there been a change in your patient's condition in the past 4-6 weeks? Yes  No

If yes, please provide details.....

.....

.....

6. Has anything happened to prolong recovery of the disabling condition (*eg underlying/ subsequent conditions, drug reactions*)? Yes  No

If yes, please provide details.....

.....

.....

**Additional Comments**

.....

.....

.....

.....

.....

**CURRENT CAPACITY QUESTIONNAIRE**

Patient's Name: .....

DOB: ..... / ..... / .....

Has your patient provided you with a copy of their job description? Yes  No

**NB. Please only complete either the Total Incapacity or Partial Incapacity Section as applicable**

**Total Incapacity**

- Current period of Total Incapacity from ..... / ..... / ..... to ..... / ..... / .....
- When do you estimate the claimant will be fit for?

Suitable/Alternate Duties	< 1 Month <input type="checkbox"/>	1-2 Months <input type="checkbox"/>	2-6 Months <input type="checkbox"/>	6-12 Months <input type="checkbox"/>	12+ Months <input type="checkbox"/>
Full Duties	< 1 Month <input type="checkbox"/>	1-2 Months <input type="checkbox"/>	2-6 Months <input type="checkbox"/>	6-12 Months <input type="checkbox"/>	12+ Months <input type="checkbox"/>

**Partial Incapacity**

- Current period of Partial Incapacity from ..... / ..... / ..... to ..... / ..... / .....
- Is the claimant able to carry out all their pre-disability duties, but restricted with the number of hours and/ or days they work? Yes  No  \_\_\_\_\_ Hours per day \_\_\_\_\_ Days per week
- Please provide details of your patient's abilities/restrictions in the table below

Activity	Able to Perform?		Capacity (Hrs/ Mins/ Weight)	Breaks Required Every: (Hrs/ Mins)
	Yes	No		
Standing				
Walking				
Climbing/ Descending Stairs				
Crawling				
Squatting				
Bending				
Kneeling				
Sitting				
Keying				
Repetitive Movements				
Operate Machinery				
Lifting (weight)				
Lifting (at height)				
Overhead work				
Travelling				
Driving				
Other _____				

I hereby certify that I have personally examined the above mentioned patient and the information given is accurate at the time of examination.

Printed Name: ..... Qualifications .....

Signature: ..... Contact Phone ( ) .....

Address: ..... Contact Fax ( ) .....

Suburb: ..... State: ..... P/Code: ..... Date ..... / ..... / .....