



Australian Government

Comcare

COMPENSATION CLAIM FOR PERMANENT IMPAIRMENT AND NON-ECONOMIC LOSS— FORM AND CHECKLIST

PRIVACY STATEMENT

Your privacy is important to us. We will only collect, use or disclose your personal information in accordance with the *Privacy Act 1988*. If Comcare does not collect personal information from you for the purposes of assessing your claim or related functions, we may not be able to determine your claim.

Comcare is the Commonwealth agency authorised by the *Safety, Rehabilitation and Compensation Act 1988* (SRC Act) to collect personal information relevant to an injured worker's claim for the purposes of managing the compensation claim and for the management of the injured worker's rehabilitation and the discharge of other functions and use of other powers under the SRC Act. For those purposes, Comcare may need to collect from, use and disclose your personal information to the following parties:

- > your employer at the date of your injury, your current employer and any subsequent employer
- > your superannuation fund manager or trustee
- > any health professional, hospitals, other health institutions, or service providers related to your claim
- > your case manager
- > your rehabilitation provider
- > vocational and functional assessor
- > employment agencies
- > legal advisors and law enforcement authorities
- > personnel engaged by Comcare to conduct research related activities
- > the Safety, Rehabilitation and Compensation Commission
- > Comcare fraud investigators
- > inspectors appointed under section 156 of the *Work Health and Safety Act 2011*
- > any relevant third party (or insurer) considered by Comcare to have contributed to the injury, illness or impairment
- > any other person assisting Comcare in the performance of its functions or exercise of its powers
- > any other entity where there is legal obligation to do so (for example, but not limited to, responding to the direction of a court to produce documentation)

We want to ensure personal information collected, used, stored or disclosed is accurate, up-to-date and complete. Comcare's Privacy Policy contains information on how you can request access to personal information held about you and how to seek correction of that information.

You may make a complaint to us if you consider that Comcare has interfered with your privacy or otherwise breached its obligations under the *Privacy Act 1988*. Our Privacy Policy contains more information about how to make a complaint and how we will respond.

Comcare is not likely to disclose personal information to a person who is not in Australia or an external Territory, unless the information relates to an incident, investigation, injury or illness sustained while overseas, or treatment provided by an overseas practitioner. If disclosure of personal information is made to an overseas recipient, Comcare will comply with obligations regarding disclosure to overseas entities (Australian Privacy Principle 8).

For further information about our information handling practices, for a copy of our Privacy Policy, to request an amendment of your personal information or to make a privacy complaint, please refer to www.comcare.gov.au/privacy, contact us on 1300 366 979 or email privacy@comcare.gov.au

This form must be completed by the employee and their treating practitioner and submitted to Comcare for assessment.

PART A—EMPLOYEE’S DETAILS

| | |
|---|-------------------------------|
| Comcare claim reference number (if known) | <div></div> / <div></div> |
| Surname | <div></div> |
| Given name(s) | <div></div> |
| Date of birth | <div> / </div> <div> / </div> |
| Postal address | <div></div> |
| | <div></div> |
| Date of injury | <div> / </div> <div> / </div> |
| Accepted condition | <div></div> |
| What permanent injury/impairment(s) of the body do you want to claim for? | <div></div> |

Have you received a lump sum award for permanent impairment or non-economic loss for this injury/injuries/disease and/or this claim or any other claim with other insurers? ☐ Yes ☐ No

If yes, please provide the following:

| | | | |
|--|-------------------------------|-----------------|-------------------------------|
| Date of award | <div> / </div> <div> / </div> | Amount received | <div></div> |
| Insurer/authority | <div></div> | | |
| Represented by (solicitor’s or other representative’s name, if applicable) | <div></div> | | |
| Signature | <div></div> | Date | <div> / </div> <div> / </div> |

PART B—TREATING PRACTITIONER TO COMPLETE

Diagnosis of the condition your patient is claiming permanent impairment for:

Is this related to their accepted condition? ☐ Yes ☐ No If you have answered no, proceed to signature.

If you have answered yes, what impairment(s) to their > bodily parts > bodily functions > bodily systems have resulted from the condition?

Do you consider that the impairment(s): > have stabilised at this level indefinitely? > will improve? > will deteriorate?

Has active treatment of the condition been completed? ☐ Yes ☐ No

If the impairment has not yet stabilised, how long do you expect it will take to stabilise?

Please describe the extent of the impairment(s) listed above. If possible, express this as a percentage of the affected body part, function or system and provide comments on how you determined the percentage.

Note: Reasonable Costs of completing this form will be met by Comcare. Prompt payment will be made if you send your account direct to Comcare, GPO Box 9905, Canberra ACT 2601.

Treating practitioner details

| | | | |
|-----------------|---|------|--|
| Name | <input type="text"/> | | |
| Address | <input type="text"/> | | |
| | <input type="text"/> | | |
| Phone | <input type="text" value="("/> <input type="text"/> | Fax | <input type="text" value="("/> <input type="text"/> |
| Qualifications | <input type="text"/> | | |
| Specialisation | <input type="text"/> | | |
| Provider number | <input type="text"/> | | |
| Signature | <input type="text"/> | Date | <input type="text" value="/"/> <input type="text" value="/"/> <input type="text"/> |

PART C—NON-ECONOMIC LOSS QUESTIONNAIRE

You need to ensure all sections of the form are completed.

Please indicate the score you consider is appropriate and use the space provided to make comments that support your answers. We request that you provide comments to help your Impairment Assessment Officer assess your claim.

If there is not enough room on the form for your comment please attach a separate, signed statement.

If you have more than one accepted condition (injury) and are claiming for a permanent impairment or impairments resulting from each condition (injury), then you must complete a separate *Non-economic loss questionnaire* for each condition.

Section 1: Pain and suffering

This section has two parts:

- > The first part on pain concerns the frequency and intensity of physical pain that you suffer due to your condition.
- > The second part on suffering concerns the mental distress that you may experience including emotional symptoms such as grief, frustration, fear, anguish, humiliation and embarrassment.

Part 1: Pain

Please note that:

- > only ongoing pain of a continuing or episodic nature is considered
- > you cannot use the table below to indicate temporary pain or speculation of future pain.

Indicate in the table which one of the following best describes the pain you suffer from:

- > No pain experienced (score 0).
- > Intermittent attacks of pain of nuisance value only. Can be ignored when activity commences (score 1).
- > Intermittent attacks of pain. Not easily tolerated, but short-lived. The pain responds fairly readily to treatment such as analgesics and anti-inflammatory medications (score 2).
- > Episodes of pain more persistent. Not easily tolerated. Treatment, if available, is of limited benefit (score 3).
- > Pain occurring most of the time. Restrictions on activity. Resistant to treatment (score 4).
- > Pain continuous and severe. Preventing activity. Uncontrolled by medication (score 5).

Table 1.1

| Employee’s score | Treating practitioner/Specialist’s score | Examining practitioner’s score |
|------------------|--|--------------------------------|
| | | |

Use the space below to give further evidence or examples that support the score you have provided.

Employee’s comments

Treating practitioner’s assessment

Examining practitioner’s assessment

Part 2: Suffering

Please note that:

- > only ongoing suffering of a continuing or episodic nature is considered
- > you cannot use the table below to indicate temporary suffering or speculation about future suffering.

Indicate in the table which one of the following best describes the suffering (mental distress) you experience:

- > No symptoms of mental distress experienced (score 0).
- > Symptoms of mental distress minimal or ill defined. Symptoms occur intermittently. No interference with activity (score 1).
- > Distinct symptoms of mental distress that are episodic in nature. Activities reduced during such episodes. Recovers quickly after episodes (score 2).
- > Symptoms of mental distress are distinct and varied. Episodes of mental distress occur regularly. Ability to cope or perform activity effectively reduced during episodes. Needs time to recover between episodes. Treatment such as anti-depressants, counselling and other supportive therapies help to control or relieve symptoms (score 3).
- > Symptoms of mental distress are wide ranging and tend to dominate thinking. Rarely free of symptoms of mental distress. Difficulty coping or performing activity. Treatment necessary to either control or relieve symptoms (score 4).
- > Symptoms of mental distress arising from accepted condition predominate over thinking. Activities severely restricted. Treatment of no real benefit in controlling or relieving symptoms (score 5).

Table 1.2

| Employee's score | Treating practitioner/Specialist's score | Examining practitioner's score |
|------------------|--|--------------------------------|
| | | |

Use the space below to give further evidence or examples that support the score you have provided.

Employee's comments

Treating practitioner's assessment

Examining practitioner's assessment

Section 2: Loss of amenities

Loss of amenities can also be described as loss of enjoyment of life.

This section has three parts:

- > The first part on mobility concerns your ability to move around in your environment including your home and work. It includes walking, driving, being a passenger, and using public transport.
- > The second part on social relationships concerns your ability to engage in your social and personal relationships.
- > The third part on recreational and leisure activities concerns your ability to maintain your usual recreational and leisure pursuits.

Part 1: Mobility

Indicate in the table which one of the following best describes the effect your condition has on your ability to move around:

- > No or minimal restrictions on mobility (score 0).
- > Periodic effects on mobility—no restrictions in-between episodes (score 1).
- > Ongoing, mild restrictions on mobility (for example, walks at a slower pace or needs a walking stick) (score 1).
- > Mobility reduced, but remains independent of others both within and outside the home. Can travel but may need to have breaks or special seating (score 2).
- > Mobility markedly reduced. Needs some assistance from others. Unable to use most forms of transport (score 3).
- > Restricted to home and vicinity. Can only travel outside home with door-to-door transport and the assistance of others (score 4).
- > Severely restricted mobility (for example, restricted to bed, chair or room). Dependent on others for assistance. Mechanical devices or appliances used for mobility within the home (for example, wheelchair, hoist) (score 5).

Table 2.1

| Employee’s score | Treating practitioner/Specialist’s score | Examining practitioner’s score |
|------------------|--|--------------------------------|
| | | |

Use the space below to give further evidence or examples that support the score you have provided.

Employee’s comments

Treating practitioner’s assessment

Examining practitioner’s assessment

Part 2: Social relationships

Indicate in the table which one of the following best describes the effect your condition has had on your personal or social life.

- > Usual relationships unaffected (score 0).
- > Minor interference with personal relationships, causing some reduction in social activities and contacts (score 1).
- > Relationships confined to immediate and extended family and close friends, but unable to relate to casual acquaintances (score 2).
- > Difficulty in maintaining relationships with close friends and extended family (score 3).
- > Social contacts confined to immediate family (score 4).
- > Difficulties relating socially to anyone (score 5).

Table 2.2

| Employee’s score | Treating practitioner/Specialist’s score | Examining practitioner’s score |
|------------------|--|--------------------------------|
| | | |

Use the space below to give further evidence or examples that support the score you have provided.

Employee’s comments

Treating practitioner’s assessment

Examining practitioner’s assessment

Part 3: Recreational and leisure activities

Indicate in the table below which one of the following best describes the effect your condition has on your usual participation in recreational and leisure activities.

- > Able to follow usual recreational and leisure activities (score 0).
- > Intermittent interference with activities. Able to pursue usual activities in-between episodes (score 1).
- > Interference with activities reduces frequency of activity, but is able to continue. Is able to enjoy alternatives (score 2).
- > Unable to continue with pre-injury level of activity. Alternative, less-rewarding activity possible (score 3).
- > Range of pre-injury activities greatly reduced. Needs some assistance to participate in pre-injury recreational and leisure activities (score 4).
- > Unable to undertake any pre-injury recreation and leisure activities (score 5).

Table 2.3

| Employee’s score | Treating practitioner/Specialist’s score | Examining practitioner’s score |
|------------------|--|--------------------------------|
| | | |

Use the space below to give further evidence or examples that support the score you have provided.

Employee’s comments

Treating practitioner’s assessment

Examining practitioner’s assessment

Section 3: Other loss

This section is for any other non-economic loss suffered as a result of your condition. This does not include factors covered earlier.

Indicate in the table which one of the following best describes your situation.

- > No or minimal disadvantages (score 0).
- > Moderate disadvantages. For example, dependence on a specialised diet, experiences detrimental effects associated with climatic features such as temperature, humidity, ultra-violet rays, light, noise or dust (score 1).
- > Marked disadvantages. For example, needs to move to specially modified premises (score 2).
- > Severe disadvantages. For example, dependence on external life-saving or supporting machines including aspirator, respirator, dialysis machine, or any form of electro-mechanical device for the sustenance or extension of activities (score 3).

Table 3.1

| Employee’s score | Treating practitioner/Specialist’s score | Examining practitioner’s score |
|------------------|--|--------------------------------|
| | | |

Use the space below to give further evidence or examples that support the score you have provided.

Employee’s comments

Treating practitioner’s assessment

Examining practitioner’s assessment

PART D

AUTHORISATION, ACKNOWLEDGEMENT AND WARNINGS

Please read and sign this authorisation and declaration.

1. I authorise and consent to:
- ii. Comcare collecting my personal information from, using it, and disclosing my personal information to any of the parties listed in the 'Collection, use and disclosure' notice on page 1 of the claim form.
 - iii. any of the above parties collecting my personal information from, using it and disclosing my personal information to Comcare or each other;
 - iv. a photocopy of this Authority as sufficient evidence of my authority and consent to discuss or provide the information requested.
5. I acknowledge and understand this consent includes collecting, using or disclosing information from, to and between parties in relation to my compensable and any non-compensable conditions.
6. I acknowledge and understand that if I refuse to give my consent, or if I restrict my consent, or if I withdraw my consent to collect, use or disclose my personal information, and Comcare believes:
- i. that I have information relevant to my claim; or
 - ii. that I can obtain information relevant to my claim without unreasonable expense or inconvenience,
- Comcare can issue me a written notice requesting me to give the information to Comcare.
3. I acknowledge and understand that if I refuse or fail, without reasonable excuse, to comply with such a written notice, Comcare may refuse to deal with my claim until I provide the information or copy of a document referred to in the notice.
4. I am aware that I must advise Comcare immediately if I engage in any employment, whether paid or not, or in the running of a business in my own right or as a partner during the period I am absent from work as a result of this injury/disease.
5. I am aware that I must advise Comcare if my injury or disease improves during any period of incapacity sufficiently to allow me to return to work;
6. I am aware that giving false or misleading information in support of this claim is a serious offence which is punishable by law under the *Criminal Code Act 1995*.
7. I am aware that any monies paid by Comcare as a result of a false or misleading statement or claim will be recovered
8. I acknowledge that I have read and understand both the 'Collection, use and disclosure' notice and the 'Authorisation, Acknowledgement and Warning' notice.
9. If someone has assisted me to complete this form, I acknowledge that they have explained the above notices to me and I understand my obligations.

Signature

Date

/ /

Print name

PART E

TREATING PRACTITIONER/SPECIALIST TO COMPLETE

Is there likely to be any reduction in life expectancy? ☐ Yes
☐ No

If yes, what is the likely reduction in the employee’s life expectancy due to injury or impairment?

☐ Less than 1 year ☐ More than 1 year, less than 10 years
☐ More than 10 years, less than 20 years ☐ 20 or more years

Additional comments

Treating practitioner’s details

Name and address of treating practitioner (please print):

OR stamp:

Name

Address

Phone

()

Fax

()

Qualifications

Specialisation

Provider number

Signature

Date

/ /

EXAMINING PRACTITIONER TO COMPLETE

Is there likely to be any reduction in life expectancy? ☐ Yes
☐ No

If yes, what is the likely reduction in the employee’s life expectancy due to injury or impairment?

☐ Less than 1 year ☐ More than 1 year, less than 10 years
☐ More than 10 years, less than 20 years ☐ 20 or more years

Additional comments

Examining practitioner’s details

Name and address of examining practitioner (please print):

OR stamp:

Name

Address

Phone

()

Fax

()

Qualifications

Specialisation

Provider number

Signature

Date

/ /

CHECKLIST

The purpose of this checklist is to ensure that you have completed all relevant parts of the *Compensation claim for permanent impairment and non-economic loss form* and provided the necessary information.

PART A

- Have you completed employee details? Yes ☐
- If you are represented by a solicitor or other representative, have you provided their contact details (name, address, and phone number)? Yes ☐
- If you received any previous lump sum benefits, have you provided details of these? Yes ☐

PART B

- Has your treating practitioner completed this part? Yes ☐

PART C

- Have you provided scores under all categories of the Non-Economic Loss Questionnaire? Yes ☐
- Have you provided details/comments in the space provided under each score? Yes ☐

PART D

- Have you read and understood the declaration and medical release authority? Yes ☐
- Have you signed the declaration and medical release authority? Yes ☐

PART E

- Has your treating practitioner completed this part? Yes ☐
- If yes, have they provided additional comments? Yes ☐
- Has your treating practitioner signed and dated the form? Yes ☐