Invalidity Pension Medical Report

Personal Details

Identity Card Number: * _____

Name: * _____ Surname: * _____

Quality of Life, Activities of Daily Living and Continence / Incontinence

The following sections: A, B & C are to be filled in by applicant.
The information submitted shall guide the Medical Professionals to provide a recommendation to the Director General (Social Security).

A. Quality of Life

	Activity	Yes	Yes, with special aids or assistance	No
1.	I can do my usual household chores (prepare meals, laundry, etc.) *	☐	☐	☐
2.	I can shop and / or do errands *	☐	☐	☐
3.	I can drive a vehicle and / or use public transport *	☐	☐	☐
4.	I can effectively participate in my usual and accustomed recreational *	☐	☐	☐
5.	I am able to maintain my usual day-to-day family responsibilities, including social outings *	☐	☐	☐
6.	I am able to maintain my personal / social relationships. (e.g. family, friends, colleagues, etc.) *	☐	☐	☐

If you have answered "No" to any of the above statements, please provide details:

B. Activities of Daily Living

Activity	Independent	Independent (with aids)	Independent (Requires reminders prompting and / or supervision in addition to minor assistance)	Needs extensive assistance	Totally dependent
Eating *	☐	☐	☐	☐	☐
Bathing *	☐	☐	☐	☐	☐
Grooming *	☐	☐	☐	☐	☐
Dressing *	☐	☐	☐	☐	☐
Toileting *	☐	☐	☐	☐	☐
Transferring *	☐	☐	☐	☐	☐

Please elaborate (list aids required, ability to sit / stand unaided during task, safety concerns, bed mobility, etc.) *

C. Continence / Incontinence

Select the description that **most accurately** reflects your current level of bladder and bowel control: *

	Continent (No assistance needed)	Occasional night time incontinence (once a week or less)	Daytime incontinence (more than once per week)	Daytime (daily) incontinence (requiring protective padding)	Daytime (daily) incontinence (requiring intervention by others)	Total Incontinence
Bladder	☐	☐	☐	☐	☐	☐
Bowel	☐	☐	☐	☐	☐	☐

Comment: Please note the number of incontinence pads used per day, if applicable.
Locomotion: Please comment on any difficulty with walking, provide walking distance, and list aids required.
Chronic Pain: Please comment on pain intensity, frequency, symptoms and response to treatment.

Medical Assessment Report

Part I (Current Assessment)

The following sections: Part I, II & III are to be completed by the certifying medical practitioner / consultant.
The information submitted shall guide the Medical Professionals to provide a recommendation to the Director General (Social Security).

a) **Date of Assessment** * _ _ / _ _ / _ _ _ _
D D / M M / Y Y Y Y

b) **Applicant's Details** * _____ _____ _____
Height (cm) Weight (kg) Blood Pressure

c) **Additional information for this assessment** *
This may include but is not restricted to:

- The applicant's positive attitude and / or approach to health management;
- Generic treatment and / or other programmes which have been undertaken or are already in place to improve level of functioning;
- Relevant educational, training or work history;
- Important socio-cultural issues which affect level of functioning, etc.

Instructions for Medical Practitioner / Consultant
Please provide details of diagnosis and clinical features of current conditions. You may need to attach a separate sheet.

d) **Clinical history and examination:** *
Include history, symptoms and their severity, examination findings, frequency and management of pain episodes (if applicable), treatment options, prognosis, and other features.

e) **How does this condition affect the applicant's ability to function?** *

Be specific and consider the effects due to the medical condition alone.

f) **The function impact of this condition is:** *

☐ Temporary Explain in the space below:

This is an aggravation of an existing condition ☐ Yes ☐ No

☐ Permanent Explain in the space below:

g) **What treatment is given to the applicant?** *

h) **Does the applicant have a medical history at a state hospital?** * ☐ Yes ☐ No

Does the applicant have a medical history at a private hospital or clinic? * ☐ Yes ☐ No

(If the answer is Yes, provide medical history)

Part II (Capacity for work or training)

Instructions for Medical Practitioner / Consultant

Part II is to provide a holistic summary of the applicant's current and potential capacity for work.

- Only those conditions identified as "Permanent" should be considered in assessing the applicant's work capacity.
- Please rate how the applicant's medical condition would affect his / her capacity to work over the next year.
- Please tick one option for each question.
- Please answer even if the applicant was not in employment for some time.

a) Indicate the applicant's current capacity to do any intervention *

E.g. vocational, pre-vocational and / or educational

Number of hours per week	Current	Within 6 months	Between 6 and 12 months	More than 12 months
From 0 to 7				
From 8 to 14				
From 15 to 29				
More than 30				

Type of work – Suggested suitable work *

Give reasons for work capacity and type of work recommendations *

b) Capacity to do any work with educational training, vocational training or on-the-job training *

(E.g. mainstreaming programmes not designed for people with physical, intellectual or psychiatric impairments)

Number of hours per week	Current	Within 6 months	Between 6 and 12 months	More than 12 months
From 0 to 7				
From 8 to 14				
From 15 to 29				
More than 30				

Type of work – Suggested suitable work *

Give reasons for work capacity and type of work recommendations *

c) Indicate the applicant's capacity to do any work with disability specific intervention: *

(E.g. programmes designed specifically for people with physical, intellectual or psychiatric impairments, like: vocational rehabilitation, disability employment services).

Number of hours per week	Current	Within 6 months	Between 6 and 12 months	More than 12 months
From 0 to 7				
From 8 to 14				
From 15 to 29				
More than 30				

Type of work – Suggested suitable work *

Give reasons for work capacity and type of work recommendations *

d) What type/s of assistance would be best to enable the applicant to return to work? *

No assistance Required	☐
Educational Training	☐
Vocational / Work Training and Rehabilitation	☐
On-the-job Training	☐
Voluntary Work	☐
Other means of assistance (give details)	☐
Would not benefit from participation in programmes	☐

→

e) Indicate the applicant's interest in pursuing assistance to return to work *

☐ None ☐ Minimal ☐ Moderate ☐ Substantial

Give details *

Part III (Medical Practitioner / Consultant's Details and Declaration)

I declare that to my knowledge all information given is true, complete and correct. *****

Name of Medical Practitioner / Consultant: _____

Medical Council Number: _____

Address: _____

_____

Contact Number: _____

Email: _____

_____ _____

Medical Practictioner / Consultant's Signature Date

Rubber Stamp