**Guidelines for Claimant’s Practitioner**

InjuriesBoard.ie 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, without unnecessary litigation overheads.

The Claimant must submit a report from their treating 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.

We have undertaken to have the majority of claims assessed within nine months of submission and with this time frame in mind, it is vital that your report adheres to the following guidelines: clear, concise and gives, as far as is possible, a final prognosis and likely recovery period.

Reports should

* Be submitted in a standard format as per the attached template
* 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

Where a final prognosis is not currently available we will arrange an up to date examination of the claimant.

If the claim proceeds to assessment, the Claimant will 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.

# Medical Assessment Form (Form B)

**Application Number (if available)……………………………………………...**

|  |  |  |
| --- | --- | --- |
| Claimant Name |  | |
| Address |  | |
|  |  | |
| Gender |  | |
| Marital Status |  | |
| Date of Birth |  | |
| Occupation |  | |
| Currently At Work | Yes | No |
| Height |  | |
| Weight |  | |
| R/L Hand Dominant |  | |

|  |  |
| --- | --- |
| Date of Accident |  |
| Date of Examination |  |

**Brief details of the accident/incident**

|  |
| --- |
|  |

## Injuries Sustained (including diagnostic information)

|  |  |
| --- | --- |
|  | |
| Date first Treatment Sought |  |
| From Whom was treatment received |  |
| Was patient hospitalised |  |
| Where was patient hospitalised |  |
| Period of Hospitalisation |  |
| Length of absence from Work |  |
| Number of GP visits |  |
| Number of Specialists visits, if any |  |
| Identity of Specialists, if any |  |
|  |
|  |
| Number of Physiotherapy Sessions, if any |  |
| Treatment/Investigations to date | |
|  | |

**Relevant Medical History (including previous and subsequent accidents)**

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Aggravation of pre-existing condition? | Yes No |
| If yes, please give nature of pre-existing condition? |  |
| Give details of previous accident history, if any |  |
| Was pre-existing condition symptomatic before accident? |  |

**Present Complaints**

|  |
| --- |
|  |

### Clinical Findings on Examination

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| --- |
|  |

Clinical Description of effects of Claimant’s Illness/Accident/Disablement

Practitioners should indicate the degree, if any, to which the Claimant's condition is affecting his/her ability in the following areas

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Normal** | **Mild** | **Moderate** | **Severe** | **Profound** |
| Mental Health |  |  |  |  |  |
| Learning/Intelligence |  |  |  |  |  |
| Consciousness/Seizures |  |  |  |  |  |
| Balance/Co-ordination |  |  |  |  |  |
| Vision |  |  |  |  |  |
| Hearing |  |  |  |  |  |
| Speech |  |  |  |  |  |
| Continence |  |  |  |  |  |
| Reaching |  |  |  |  |  |
| Manual Dexterity |  |  |  |  |  |
| Lifting/Carrying |  |  |  |  |  |
| Bending/Kneeling/Squatting |  |  |  |  |  |
| Sitting |  |  |  |  |  |
| Standing |  |  |  |  |  |
| Climbing Stairs |  |  |  |  |  |
| Walking |  |  |  |  |  |

|  |
| --- |
| **Anticipated treatment required into the future** |
|  |

**Opinion/Comment/Latest Prognosis**

|  |
| --- |
| Are the injuries consistent with the accident?  If not please specify |
| Are further investigations required?  If so please specify |
| Is a full recovery expected?  If not please detail likely effects on lifestyle/work |
| Please state the expected time period to full recovery |
| Are late complications expected?  If so please specify |
| Are further Specialist reports recommended?  If so please specify |
| **General Comments and Observations** |
|  |

**Completed by**

|  |
| --- |
| **Practitioner signature**  **& name in BLOCK**  **CAPITALS:** |
| **Address:** |
| **Qualifications:** |
| **Date of Completion:** |