Invalidity Pension Medical Report

Perso	onal Details			
Ident Nam	e: * Surname: *			
Qual	ity of Life, Activities of Daily Living and Continence / Incon	tinence		
The foll	owing sections: A, B & C are to be filled in by applicant. ormation submitted shall guide the Medical Professionals to provide a recommendation		or General (Social Security).	
	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:			

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B. Activities of Daily Living

ating *		(with aids)	addition	to minor assistance)	assistance	dependent
utilig						
athing *						
rooming *						
ressing *						
oileting *						
ansferring	, *					
	inence / Incontin		ects your current l	evel of bladder and bow	el control: *	
ect the des	cription that most Continent (No incassistance		ects your current Daytime incontinence (more than once per week)	evel of bladder and bow Daytime (daily) incontinence (requiring protective padding)	el control: * Daytime (daily) incontinence (requiring intervention by others)	Total Incontinence
ct the des	Continent (No incassistance (on)	asional night time continence ce a week or	Daytime incontinence (more than once	Daytime (daily) incontinence (requiring protective	Daytime (daily) incontinence (requiring intervention by	

Medical Assessment Report

Part I (Current Assessment)

	_	re to be completed by the cert the Medical Professionals to p		/ consultant. to the Director General (Social Security).	
a)	Date of Assessment *	// DD/MM/YYYY			
b)	Applicant's Details *	Height (cm)	Weight (kg)	Blood Pressure	
c)	Generic treatmlevel of functioRelevant educa	not restricted to: positive attitude and / or ent and / or other prograi	mmes which have been story;	undertaken or are already in place to imp	prove
	Clinical history and exa	is and clinical features of o		may need to attach a separate sheet.	
		ns and their severity, exan ptions, prognosis, and oth	• •	ency and management of pain episodes (i	it

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		cts due to the medical condition a			
The functio	n impact of this co	ndition is: *			
	Temporary	Explain in the space below:			
Thi	s is an aggravation c	f an existing condition	☐ Yes		☐ No
	Permanent	Explain in the space below:			
What treat	ment is given to the	e applicant? *			
Does the ap	plicant have a med	lical history at a state hospital?	*	☐ Yes	□ No
	oplicant have a med er is Yes, provide me	lical history at a private hospita	l or clinic? *	Yes	□ No

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

From 8 to 14				
From 15 to 29				
More than 30				
Type of work – Suggested suital	ble work *			
Give reasons for work capacity ar	nd type of work reco	ommendations *		
(E.g. mainstreaming pro	grammes not design	ned for people with physica	Between 6 and 12	ic impairments)
		Within O months	us o u the	More than 12 months
From 0 to 7		Within 6 Hollers	months	More than 12 months
		Within O months	months	More than 12 months
From 0 to 7		Within O months	months	More than 12 months
From 0 to 7 From 8 to 14		Within 6 months	months	More than 12 months
From 0 to 7 From 8 to 14 From 15 to 29 More than 30	ble work *	Within 6 months	months	More than 12 months
From 0 to 7 From 8 to 14 From 15 to 29	ble work *		months	More than 12 months
From 0 to 7 From 8 to 14 From 15 to 29 More than 30			months	More than 12 months

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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).

	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				
ype of work – Suggested suitab	ole work *			
iive reasons for work capacity ar	nd type of work recomi	mendations *		
d) What type/s of assista	nce would be best to	enable the applican	t to return to work? *	
No assistance Required				
140 assistance required				
Educational Training	nd Rehabilitation			
Educational Training Vocational / Work Training an	nd Rehabilitation			
Educational Training Vocational / Work Training an On-the-job Training	nd Rehabilitation			
Educational Training Vocational / Work Training an On-the-job Training Voluntary Work				
Educational Training Vocational / Work Training an On-the-job Training Voluntary Work Other means of assistance (give	ve details)			
Educational Training Vocational / Work Training an On-the-job Training Voluntary Work Other means of assistance (given	ve details) cipation in programm	□ □ □ → nes □	n to work *	
Educational Training Vocational / Work Training an On-the-job Training Voluntary Work Other means of assistance (give) Would not benefit from partic	ve details) cipation in programm	□ □ □ → nes □	n to work * Moderate	☐ Substantial
Educational Training Vocational / Work Training and On-the-job Training Voluntary Work Other means of assistance (give Would not benefit from particle e) Indicate the applicant's None	ve details) cipation in programm s interest in pursuing	□ □ □ → nes □		Substantial
Educational Training Vocational / Work Training and On-the-job Training Voluntary Work Other means of assistance (given would not benefit from particle) e) Indicate the applicant's	ve details) cipation in programm s interest in pursuing	□ □ □ → nes □		Substantial

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

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Rubber Stamp