MEDICAL FORM

Applicant's name	

To be completed by the applicant's Occupational Therapist or allied health practitioner

Full name	
Place of work (including mailing address)	
Telephone	
Email	

All following sections to be completed by the applicant's General Practitioner or Medical Specialist

Full name	
Place of work	
Telephone	

Describe the nature of applicant's physical disability
Diagnosis

Severity of mobility impairment independent / uses mobility aids. e.g. walking frame / dependent on wheelchair use.

Functional ability for self-care activities (eating, dressing, bathing, toileting) – independent / needs some assistance from others / dependent on 1:1 support).

Does the person have an intellectual disability, major psychotic illness or alcoholism? ☐ Yes ☐ No

If "Yes" state the degree of severity.

Specify type of assistance and/or equipment required

Signed

GP/ Specialist. (Not OT)

Dated / /

Please include a copy of your Centrelink Carer Payment card (not Carer Allowance card) or Disability Support Pension.