Joint Medical Examinations

Document Guide - Impairments

October 2022

Documentation Guide – PURPOSE

Introduction:

The following Documentation Guide has been developed to enhance the relevance and timeliness of medical material sent to examiners. It provides guidance to TAC staff and personal injury lawyers about the relevant and essential medical material across disciplines.

In the spirit of the Joint Medical Examination Protocols, the Documentation Guide was created in consultation with the Joint Medical Examination Reference Group. This includes representatives from the Law Institute of Victoria (LIV), the Australian Lawyers Alliance (ALA), medical examiners and the TAC.

The TAC recognises that the Documentation Guide is to be used in a practical and flexible manner. The TAC and the client's lawyers agree to take all reasonable steps to avoid irrelevant and duplicate medical material sent to examiners. Both parties have equal responsibility to ensure all necessary information has been provided to facilitate the completion of high-quality assessments and to ensure irrelevant documentation is not provided to examiners in order to maintain client privacy.

It is kindly requested that all questions and material are provided to the examiner at the earliest possible opportunity, but no later than 48 hours prior to the appointment date to allow examiners sufficient time to review the medical material to adequately prepare for the examination and to avoid the possibility of the appointment needing to be rescheduled.

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The following information is highly recommended:

- TAC Claim Form.
- Medical Certificate (most recent).
- GP reports (only send most recent GP report if it includes info from earlier reports).
- Treating specialist reports (all relevant reports).
- Radiology & Investigation reports (to be provided on disc if possible).
- Ambulance case sheets.
- Accident & emergency notes.
- Outpatient progress notes.
- Operative reports (all).
- Discharge summaries.
- Other relevant treating reports (all).
- Test results (all of those that are relevant).
- Relevant pre-existing – see next column.

Note: Treating reports should be provided in the first instance (reports should clearly detail any relevant pre accident conditions and the post MVA status of those conditions).

Pre-Existing Information (the following information is highly recommended):

- Any relevant GP/ specialists reports.
- Any legible GP/ specialists notes.
- Any relevant information from any relevant previous or subsequent TAC claims or WorkSafe claims (i.e. 1st medical certificate, treater reports, IME reports).

Information not recommended to be sent:

- Illegible GP notes – if they are vital, please have GP translate.
- Nursing notes.
- Pathology results.
- Administrative documents.
- Previous medico-legal assessment reports (unless case previously determined and will assist for apportionment, with the exception of Psychiatric assessments).
- Client Affidavits (where they are relate to subject case).

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Cardiovascular

- Any ECG tracings or results from angiograms.
- Any documents that show Blood Pressure Readings.
- Any results from echocardiogram/cardiac Doppler/cardiac ultrasound.
- Any reports that look at flow of blood through arteries.
- Results of all blood tests taken in hospital.

Digestive

- All investigations and operative reports for any part of the bowel (oesophagus, stomach, pancreas, liver, small/large intestine, colon, anus).
- Any document detailing clients medications.
- All blood & biochemistry tests.

Endocrine (including diabetes)

- Every blood test result from any source.

ENT

- Relevant outpatient progress notes.
- All operative reports
- All radiological reports
- Hearing reports/testing pre and post MVA

Haematology (typically splenectomy assessments)

- Every blood test result from any source.

Neuropsychology (particularly head injury)

- Ambulance case sheets (including details of GCS).
- Relevant admission and inpatient progress notes (particularly detailing GCS & amnesia, ICU admissions).
- Westmead PTA scale (if available).
- Radiology reports relating to CT or MRI brain scans.
- Discharge summaries (as listed under "Essential Info").
- Treating neuropsychological assessments/ testing.
- ABI from stroke, heart attack or blood loss – send full FOI.
- School reports (minors).
- All documents detailing previous history of relevance to neurological function, e.g. learning difficulties, substance abuse, previous psychiatric issues, previous head injuries or other neurological dysfunction (this could sometimes include GP notes).
- **Psychiatric & Neurology/ Neurosurgical medico-legal reports (it is expected that these are provided to the Neuropsychologist).**

Neurology (particularly head injury)

- Ambulance case sheets (as listed under "Essential Info").
- Relevant outpatient progress notes (particularly detailing GCS & amnesia).
- Neuropsychology assessments.
- School Report or Academic results (Child & Youth 0-21 years).
- Psychiatric assessments.
- ABI from stroke, heart attack or blood loss – send full FOI.
- **Psychiatric & Neuropsychology medico-legal reports (it is expected that these are provided to the Neurologist where the client has suffered a head injury).**

Neurosurgery

- All radiological reports, films/ discs.

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Orthopaedic

- All radiological reports, films/ discs.

Psychiatric

- Treating psychiatrist/psychologist reports.
- Mental Health Treatment plan/s (if applicable).
- Neuropsychology reports.
- School Reports or Academic results (Child & Youth 0-21 years).
- Neurology assessments.
- Previous medico-legal assessment reports (where appropriate).
- **Neurology/ Neurosurgical & Neuropsychology medico-legal reports (it is recommended these are provided where the client has sustained a bran injury).**

Reproductive

- All blood & biochemistry test results – levels of various hormones are vital.

Respiratory

- All treating specialist reports.
- All lung function testing.
- Any relevant cardio information (that might impact testing).
- Any document that confirms smoking history or previous lung pathology.
- Radiology reports & films of chest & lungs – pre-existing if available.
- Any documentation that confirms weight before or after the accident.
- Any recent blood tests or documentation about anaemia.

The Skin

- Any scar revision surgery reports/information.

Urinary

- Results of all studies examining bladder & kidney function.
- All blood & biochemistry test results – key terms are serum creatine & serum creatinine.

Visual System

- Any visual tests from any source pre and post MVA.
- Anything in FOI that refers to visual system – key terms are medmont, hemianopia, CN III, CNIV, CN VI.