Documentation Guide

Medical Examinations for Impairment, Serious Injury and Common Law

April 2025

Transport Accident Commission

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Purpose

This 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. It is relevant to examinations for impairment, serious injury and common law.

In line with the principles of the Joint Medical Examination Protocols, the Documentation Guide was reviewed in consultation with members of the Law Institute of Victoria (LIV) and the Australian Lawyers Alliance (ALA).

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 and to avoid unnecessary costs.

All questions and material should be provided to the examiner, and a copy sent to the TAC, at the earliest opportunity, no later than 14 days prior to the appointment date. This allows 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.

Recommended Information Summary

This summary information table **must** be read alongside the recommended information by specialty detailed on pages 6 to 9.

Key	
✓	Information is always required.
✓ If relevant	Only send information if relevant to the examination (or for specific conditions as indicated).

Please ensure the examiner receives information linking injury to accident. This is particularly important if the client is seeking compensation for an unconfirmed injury that has not been assessed or liability accepted by the TAC.

All materials provided to examiners must be up to date. ‘Up to date’ medical records refer to current and accurate documentation of the client's health, history, diagnosis, treatments, medications, test results and other relevant information.

Information type	
TAC claim form	✓
Relevant information from previous or subsequent TAC or WorkSafe claims	✓
Ambulance case sheets	✓
Hospital admission, emergency, discharge summaries, investigations and rehab progress reports	✓
Operation and procedure reports	✓
General Practitioner(s) consultation notes (as current) **Note:** *Pre-accident clinical records are required if there is a pre-existing condition or aggravation.*	✓
Treating specialist(s) consultation notes (as current) or report where relevant	✓
Medication summary • Psychiatric and/or Psychological injury • Pain Conditions	✓
Medication summary – other injury types	✓ If relevant
Medical certificates (initial and most recent)	✓ If relevant
General Practitioner reports ***Note:*** *If clinical notes have been provided, a GP report can be considered where relevant*.	✓ If relevant
Outpatient progress notes	✓ If relevant
Radiology reports	✓ If relevant
Occupational therapy reports	✓ If relevant
Treatment plans (ie Allied Health, MH, PMP, Dental)	✓ If relevant
Vocational assessment reports	✓ If relevant
Pain diaries/charts	✓ If relevant

Information not recommended to be sent

Key	
×	Information is not required.
#	Information to be provided only in limited circumstances

Information type	
Handwritten/Illegible GP notes – if they are vital, please have GP translate	×
Nursing notes	×
Pathology results (unless relevant for the examination)	×
Administrative documents	×
Full Hospital FOI Note: *Only in rare cases would it be necessary to provide the examiner with the entire hospital file. Please refer to pages 6 to 9 for guidance on selecting the appropriate records for each discipline.*	×
Client affidavits (where they are related to subject case)	#
Other medico-legal assessment reports Exemptions: • Exchanging medico-legal assessment reports between the disciplines of Psychiatry, Neurology and Neuropsychology • Exchanging prior medico-legal assessments of the same discipline **Note:** *Other medico-legal assessment reports can be exchanged across other disciplines via a supplementary report request after an examiner has provided their initial independent assessment and report.*	#

Recommended information by specialty

Cardiovascular

- Any ECG tracings or results from angiograms
- Any documents that show blood pressure readings
- Any results from echocardiogram, cardiac Doppler, or cardiac ultrasound
- Any reports that look at flow of blood through arteries
- Blood pressure readings
- Results of all blood tests taken in hospital
- Pathology results (relevant)

Dental (oral maxillofacial surgery)

- Radiology reports, films and discs
- Dental treatment plans/reports

Ear, nose and throat

- Relevant outpatient progress notes
- Operation reports
- All radiological reports, films and discs
- Hearing reports/testing pre- and post-MVA

General surgery (including digestive)

- All investigations and operative reports for any part of the bowel (oesophagus, stomach, pancreas, liver, small/large intestine, colon, anus)
- Any document detailing client's medications
- All blood and biochemistry tests.
- Endocrine results (including diabetes)
- Every blood test result from any source
- Relevant outpatient progress notes
- Pathology results (relevant)

Haematology (typically splenectomy assessments)

- Every blood test result from any source

Recommended information by specialty (cont.)

Neurology (head injury)

- Relevant outpatient progress notes (particularly detailing GCS and amnesia)
- All radiology reports, films and discs
- Neuropsychology assessments
- School reports or academic results (children and youth, age 0 to 21)
- Psychiatric assessments
- ABI from stroke, heart attack or blood loss (send full FOI)
- Psychiatric and neuropsychology medico-legal reports
- Relevant outpatient progress notes

Neurology (nervous system)

- All radiology reports, films and discs (relevant)
- Treating neurological assessments/testing (e.g. nerve conduction study reports)
- Treating specialist consultation records (relevant)
- Relevant outpatient progress notes

Neuropsychology (particularly head injury)

- Relevant admission and inpatient progress notes (particularly detailing GCS and amnesia, ICU admissions)
- Westmead PTA scale (if available)
- Radiology reports relating to CT or MRI brain scans
- 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 and neurology/neurosurgical medico-legal reports – it is expected that these are provided to the neuropsychologist
- Relevant outpatient progress notes

Neurosurgery

- All radiological reports, films and discs
- Operation reports
- Treating specialist consultation records (relevant)
- Relevant outpatient progress notes

Recommended information by specialty (cont.)

Occupational medicine

- All radiological reports, films and discs
- Operation reports
- Vocational assessment reports
- Occupational therapy reports
- Allied Health Treatment Plan/s (if relevant)
- Relevant outpatient progress notes

Orthopaedic

- All radiological reports, films and discs
- Operation reports
- Treating specialist consultation records (relevant)
- Allied Health Treatment Plan/s (if relevant)
- Relevant outpatient progress notes

Pain management

- Treating specialist consultation records (relevant)
- Operation and procedure reports (e.g. pain implants, radiofrequency neurotomy etc.)
- Pain diaries/charts
- Medication summary
- Allied Health Treatment Plan/s (if relevant)
- Relevant outpatient progress notes

Psychiatric

- Treating psychiatrist/psychologist reports
- Mental Health Treatment Plan/s (if applicable)
- Neuropsychology reports
- School reports or academic results (children and youth age 0 to 21)
- Neurology assessments
- Previous medico-legal assessment reports (where appropriate)
- Neurology/Neurosurgical and neuropsychology medico-legal reports – it is recommended these are provided where the client has sustained a brain injury
- Relevant outpatient progress notes
- Inpatient admission reports
- **Do not send:** radiology reports (except imaging relating to an ABI), nerve conduction studies results, OT reports, operation & procedure reports, full hospital FOI, hearing testing/reports (pre & post MVA)

Rehabilitation medicine

- Treating specialist consultation records (relevant)
- Operation reports
- Pain diaries
- Medication summary
- Allied Health Treatment Plan/s (if relevant)
- Occupational therapy reports
- Relevant outpatient progress notes

Recommended information by specialty (cont.)

Reproductive

- All blood and biochemistry test results – levels of various hormones are vital
- All radiology reports, films and discs (relevant)

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 and films of chest and lungs (pre-existing if available)
- Any documentation that confirms weight before or after the accident
- Any recent blood tests or documentation about anaemia

Rheumatology

- Treating specialist consultation records (rheumatology)
- All radiology reports, films and discs (relevant)
- Pathology results (relevant)
- Relevant outpatient progress notes
- Endocrine results

Skin (Plastic surgery)

- Any scar revision surgery reports/information

Urinary (Urology)

- Results of all studies examining bladder and kidney function
- All radiology reports, films and discs (relevant)
- All blood and biochemistry test results (key terms are serum creatine and serum creatinine)
- Pathology results (relevant)

Visual system (Ophthalmology)

- Any visual tests/reports from any source pre- and post-MVA
- Anything in FOI that refers to the visual system (key terms include medmont, hemianopia, CN III, CNIV, CN VI)

Any questions?

Contact jmerequests@tac.vic.gov.au

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