

# Sickness and Invalid's Benefit

## MEDICAL CERTIFICATE

This information will be used to establish the person's entitlement to benefit, and will assist in helping plan their entry into work.

### Personal details Client Number

First Name: \_\_\_\_\_ Surname or family name: \_\_\_\_\_  
Residential Address: \_\_\_\_\_

Auckland

Date of birth: \_\_\_\_\_ Gender: **Male**

1. Enrolment Status: **Confirmed Enrolment**

2. Who do you consider best placed to provide this information, (circle one) **Yourself** | Second opinion | Other \_\_\_\_\_

### Pregnancy

3. Is the condition pregnancy related?(circle one) **No** (go to Q7) Yes (due date) \_\_\_/\_\_\_/\_\_\_ (go to Q20)

4. Has the baby been born? *Read Code L20* Yes Date of delivery \_\_\_/\_\_\_/\_\_\_ (go to Q20)

or  
Is the person 27 or more weeks pregnant? *Read Code ZV22* Yes

or  
Is the person less than 27 weeks pregnant with complications? Yes (give details)

(1) READ Code \_\_\_\_\_ Description \_\_\_\_\_

(2) READ Code \_\_\_\_\_ Description \_\_\_\_\_

5. Unable to Work from \_\_\_/\_\_\_/\_\_\_

6. When should the person's entitlement to benefit next be assessed \_\_\_/\_\_\_/\_\_\_ (go to Q20)

### Sickness, Injury or Disability:

7. What are the main clinical conditions affecting the persons ability to work?

(1) READ Code F2300 Description Alcohol dependence

(2) READ Code \_\_\_\_\_ Description \_\_\_\_\_

(3) READ Code \_\_\_\_\_ Description \_\_\_\_\_

(4) READ Code \_\_\_\_\_ Description \_\_\_\_\_

8. If covered by ACC, what is the ACC Number?:

### Hospitalisation

9. Is the person in hospital? (Circle one) **No** (go to Q10) Yes

Hospital Name \_\_\_\_\_

Date of admission \_\_\_/\_\_\_/\_\_\_

Expected length of stay \_\_\_\_\_ days

### Treatment and Interventions

Questions 10 and 11 relate to planning rather than entitlement. Their completion is therefore optional.

10. Is the person receiving active treatment for any of the conditions listed in Question 7?(circle one)  
\_\_\_\_\_ counselling \_\_\_\_\_ No Yes

11. Are there other interventions which could assist the person into work? (Circle one)  
\_\_\_\_\_ Change to invalids benefits \_\_\_\_\_ No Yes (please give details)

**Impact on ability to work**

12. How do the above conditions listed in Question 7 effect the person's ability to work?

Details Prolonged counselling at

13. When is the person likely to be capable of: (circle as applicable)

Work Planning: Now | < 1 Month | 1-3 months | 3-6 Months | Unlikely in foreseeable future

Training: Now | < 1 Month | 1-3 Months | 3-6 months | Unlikely in foreseeable future

Light/Selected duties: Now | < 1 Month | 1-3 Months | 3-6 Months | Unlikely in foreseeable future

Part time work: (up to 30hrs/wk: Now | < 1 Month | 1-3 Months | 3-6 Months | Unlikely in foreseeable future

Full time work: (over 30 hrs/wk) Now | < 1 Month | 1-3 Months | 3-6 Months | Unlikely in foreseeable future

14. Is the person totally blind (VA<1/20 with correction) (circle one) No Yes (go to Q19)

15. Does the person's sickness, injury, or disability limit their capacity to seek, undertake or be available for employment for 30 hours or more per week? (circle one) No Yes

16. Does the person's sickness, injury, or disability prevent them from regularly being in open employment for 15 hours or more per week? (circle one) No Yes

17. Is the person's condition expected to last at least 2 years? No Yes

or  
Is the person's life expectancy less than 2 years? No Yes

18. Unable to work from 19.6.08

19. When should the person's entitlement to benefit next be assessed (select one)

11 | 2 years | 5 Years | Never

**Comments**

20. Would you like Work and Income to contact you about this person's diagnosis or ability to work? (circle one) No Yes

21. Please provide any comments that would assist the case manager determine appropriate support for the person.

Change to Invalids benefit.

**Health Practitioner Identity**

HPI No. \_\_\_\_\_ Profession type: (circle one) Doctor | Dentist | Midwife

I have discussed the information contained in this form with the person (their guardian or legal representative) and they have agreed with the information being provided to Work and Income (circle one)

Full Name: \_\_\_\_\_

Practice address: \_\_\_\_\_, Auckland.

Telephone Number: \_\_\_\_\_

Date person examined: 17/6/08

Date Certificate completed: 19 Jun 2008

Signature: \_\_\_\_\_