Australian Government
Services Australia

centrelink

# Verification of medical condition(s) (SU684)

**This information will help Services Australia to:**

- confirm details of the main medical conditions affecting the person's capacity to work
- assess how these conditions affect the person's capacity to work or take part in other activities
- recommend assistance which could help the patient into work or maintain employment.

**This form is not a medical certificate.** It is **not** used to determine whether a person can be granted an exemption from their Mutual Obligation Requirements. Mutual Obligation Requirements means Activity Test or participation requirements under the *Social Security Act 1991*.

## Instructions for the customer

1. Contact your medical practitioner and make an appointment to have this form completed.

   Make sure the medical practitioner and their receptionist know that you will need this form completed, as a long consultation may be required. If your medical practitioner does not bulk bill, your consultation fee may be more than usual because of the extra time taken to complete the form.

2. Attend the appointment with your medical practitioner.

3. If your medical practitioner returns the completed form to you, return it:
   - **online** (excluding identity documents) using your Centrelink online account. For more information, go to **servicesaustralia.gov.au/centrelinkuploaddocs**

   If you have any questions about this form, call us on **132 717**.

   Call charges may apply.

**Important information –** This request is a notice given under section 63 of the *Social Security (Administration) Act 1999*.

## Privacy notice

### Privacy and your personal information

The privacy and security of your personal information is important to us, and is protected by law. We collect this information so we can process and manage your applications and payments, and provide services to you. We only share your information with other parties where you have agreed, or where the law allows or requires it. For more information, go to **servicesaustralia.gov.au/privacy**

## Information for the medical practitioner

### Completing this form

In this form you will be asked to provide information about your patient's medical condition(s). Complete all the required questions in this form.

If your patient is temporarily incapacitated for all work of at least **8 hours per week**, complete a **Medical Certificate (SU415)** form instead of this form. You can complete and lodge Medical Certificates electronically through Health Professional Online Services (HPOS). For more information go to **servicesaustralia.gov.au/hpos**

If you require another copy of this form, go to **servicesaustralia.gov.au/forms**

If you need more information in order to complete this form, call us on **132 150**.

Call charges may apply.

### Request for clarification of additional information

Services Australia, including staff from the Health Professional Advisory Unit, may make contact with you to discuss the information in this form. These contacts will only occur where information requires clarification.

### Reimbursement for services

We have asked your patient to let you (and your receptionist) know at the time of making their appointment that they require you to complete this form. This is to make sure that you have sufficient time for the examination and completion of the report. The time taken to complete this report counts towards the length of the consultation. You can claim it as a long consultation.

### Release of medical information

The *Freedom of Information Act 1982* allows for the disclosure of medical or psychiatric information directly to the individual concerned. If there is any information in this form which, if released to your patient, may harm their physical or mental well-being, provide a statement identifying it and briefly state why it should not be released directly to the patient. Similarly, specify any other special circumstances which should be taken into account when deciding on the release of this form.

### Returning this form

You can give this form to your patient or return it **by post to:**

**Services Australia**
**Disability Services**
**PO Box 7806**
**CANBERRA BC ACT 2610**

## Medical practitioner privacy notice

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**Patient's details**

Family name: **Marth**

Given name(s): **Armin**

Address: **38 Alliot Mews**

**Edmondson Park NSW** Postcode **2174**

Date of birth (DD MM YYYY): 25 04 1989

Customer Reference Number: 208 063 801 X

| **Condition 1** | **Condition 2** | **Condition 3** |
|---|---|---|
| **Diagnosis** — List the medical condition(s) which impact most on the patient's capacity to work or study | | |
| Autism Spectrum Disorder level 1 | Anxiety disorder | |
| **Prognosis** — **1** – Temporary, **2** – Permanent (likely to persist for 2 years or more), **3** – Prognosis unclear | | |
| **Tick ONE only** 1 ☐ 2 ☒ 3 ☐ | **Tick ONE only** 1 ☒ 2 ☐ 3 ☐ | **Tick ONE only** 1 ☐ 2 ☐ 3 ☐ |
| **Date of onset** (DD MM YYYY) (if known) 02 10 2019 | **Date of onset** (DD MM YYYY) (if known) 02 10 2019 | **Date of onset** (DD MM YYYY) (if known) |
| **Current symptoms** — List current symptoms | | |
| Poor social skills, lack of empathy | Stress | |
| **Treatment** — Describe the patient's treatment regime, including past, current and planned treatment | | |
| Past: | Past: | Past: |
| Current: Psychology, employment support | Current: Psychology | Current: |
| Planned: | Planned: | Planned: |

**Other medical conditions** — Give details of any co-morbid conditions which significantly impact on the patient's capacity to work or study

**Recommended assistance** — List any recommendations which could help the patient into work or maintain employment.

**Details of medical practitioner completing this form**

Medical practitioner's name (printed): Kirollos Roman

Qualifications: BMedSt, MD, FRACGP Provider no. 5422416K

Surgery/Medical Centre/ Hospital name: Myhealth Edmondson Park

Address: Shop A101, Edmondson Square

52 Soldiers Parade Postcode 2174

Phone number (including area code): 87864448

Signature:

Date (DD MM YYYY): 06 02 2024

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