

## Your reply

Please complete **both** sides of this form, then send it back to us in the envelope we have sent you. Make sure the address below shows in the window of the envelope.

Office contact name and address:

Client's name

Client's NI number

Client's date of birth

Please answer the following questions from the information which is currently available to you. If you need more space for any of your answers, please continue at **Part 7**.

### 1 When did your patient last see a GP?

### 2 Current conditions affecting ability to work

Please give us details of those conditions **which may have a significant effect on the person's capacity to work**.

Please include:

- Relevant symptoms and signs, including side effects of medication, with dates. For mental health conditions, please provide brief mental state examination findings, if available.
- Past, present and planned investigations and management, including medication, **where relevant**. If you are sending a computerised printout of current medication you do not need to list this here.

Condition and date of diagnosis	Symptoms and signs	Investigations and management, including medication

**3 Current conditions not affecting ability to work**

Please **list** any other relevant conditions that do not affect the ability to work.

**4 If known from your knowledge of the patient**, please tick the boxes that apply and provide a brief explanation if your patient has difficulties with any of the following activities:

- Walking
- Rising from sitting
- Picking up objects
- Reaching
- Manual dexterity
- Continence
- Maintaining personal hygiene
- Eating or drinking
- Initiating or completing simple tasks
- Communication

**5 Does the patient have a history of threatening or violent behaviour?**

**No**

**Yes**

Tell us about their behaviour within the last 5 years, and whether they have been identified by the Zero Tolerance (Violent Behaviour) Initiative. Use the space below at **Part 7**.

**6 Could your patient travel to an examination centre by public transport or taxi?**

**No**

**Yes**

Please tell us why at **Part 7**.

**7 Additional information**

Please continue on a separate sheet if necessary.

The information you have given us may be copied to the patient, their legal representative or the Tribunals Service.

**Your signature**

Practice stamp

**Name** IN CAPITALS

**Date**