Instructions

Australian Government
Services Australia

centrelink

Verification of medical condition(s) (SU684)

When to use this form

Use this form so we can:

- assess how medical condition(s) affect your capacity to work or take part in other activities
- recommend assistance which could help you 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 needed. 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 gives the completed form to you, return it to us 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**.

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/privacypolicy**

Information for the medical practitioner

Completing this form

This form asks you 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 need:

- another copy of this form, go to **servicesaustralia.gov.au/forms**
- more information in order to complete this form, call us on **132 150**.

We may contact you

We may contact you to discuss the information in this form if we need you to explain it.

Reimbursement for services

We have asked your patient to let you (and your receptionist) know at the time of making their appointment that they need you to complete this form. This is to make sure that you have enough time to complete the examination and 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* lets us disclose medical or psychiatric information to the patient. If you do not want information in this form released to the patient because it may harm their physical or mental well-being, include the details in a statement and explain why.

Returning this form

You can:

- give this form to your patient, or
- return it, and any supporting statement to us by post:

  Services Australia
  Disability Services
  PO Box 7806
  CANBERRA BC ACT 2610

Medical practitioner 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 to provide payments and services. 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/privacypolicy**

Instructions

Clear

Patient's details

Family name

Given name(s)

Address

Postcode

Date of birth (DD MM YYYY)

Customer Reference Number (if known)

Condition 1 **Condition 2** **Condition 3**

Diagnosis — List the medical condition(s) which impact most on the patient's capacity to work or study

Prognosis — **1 –** Likely to persist for less than 2 years, **2 –** 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)

Date of onset (DD MM YYYY) (if known)

Date of onset (DD MM YYYY) (if known)

Current symptoms — List current symptoms

Treatment — Describe the patient's treatment regime, including past, current and planned treatment

Past:

Current:

Planned:

Past:

Current:

Planned:

Past:

Current:

Planned:

Other medical condition(s) — Give details of any co-morbid condition(s) 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)

Qualifications

Provider no.

Surgery/Medical Centre/ Hospital name

Address

Postcode

Phone number (including area code)

Signature

On completion of this form, print and sign by hand

Date (DD MM YYYY)

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