

PIAB MEDICAL ASSESSMENT FORM (FORM B) – INFORMATION
FOR MEDICAL PRACTITIONERS

PIAB is Ireland's independent state body which assesses personal injury compensation. PIAB's objective is to ensure that those making personal injury claims for injuries sustained in accidents have their compensation assessed quickly and fairly and without unnecessary litigation costs. In order for PIAB to assess a claim, a claimant as part of their application must submit a medical report from their treating medical practitioner. This form is provided as a template for treating doctors to submit a medical report to PIAB. It will also be used by members of PIABs independent panel of medical examiners. Copies of medical reports will be passed to the respondent/s (the person/s against whom the claim is being made) and their insurers where known, in order that they may know the nature and extent of the claim. As a result the medical report should only contain medical history relevant to the claim being made.

Medical reports should

- ✓ be submitted in a standard format as per the attached template and typed,
- ✓ be as clear and concise as possible,
- ✓ include relevant details of the claimant's medical and accident history and advise whether the accident has exacerbated any pre-existing symptoms/injury,
- ✓ contain an opinion/prognosis on the likely recovery time for the claimant's injuries to resolve (if a full recovery is unlikely, the report should outline the residual symptoms likely to be suffered by the claimant and what effect these will have on their lifestyle/work),
- ✓ include good quality photographs where appropriate or requested,
- ✓ only contain medical history/information relating to the claimant (and not medical history/information about any third party).

If the claim proceeds to assessment, the claimant may be awarded the reasonable and necessary cost of this medical report. PIAB will where required arrange an up to date medical examination of the claimant.

The Personal Injuries Guidelines as adopted by the Judicial Council of Ireland requires us to have consideration to certain matters and therefore additional fields have been included in the form which should be completed by practitioners, namely:

- The claimant's dominant or most significant injury
- Impact on the lifestyle of the claimant
- The period in which substantial recovery has taken place
- The extent to which any pre-existing condition has been made worse and the duration of any increased symptomology.

Practitioners should also have regard to the following when considering their opinion and prognosis:

- i. Age;
- ii. Nature, severity and duration of injury and consequential symptoms;
- iii. Interference with quality of life and leisure activities;
- iv. Impact on work;

- v. Impact on interpersonal relationships;
- vi. Whether medical assistance has been sought and the extent of required medical intervention and treatment;
- vii. Presence or risk of underlying vulnerability;
- viii. Success or likely success of treatment;
- ix. Prognosis.

The Personal Injury Guidelines are available at the following website:

<https://judicialcouncil.ie/assets/uploads/documents/Personal%20Injuries%20Guidelines.pdf>

PIAB Medical Assessment Form (Form B)

PIAB application Number	
Examining Doctors Name	
Claimant name	
Address	
Gender	
Date of birth	
Occupation (including details of any change since the date of accident)	
Currently at work?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Right or left hand dominant?	Right <input type="checkbox"/> Left <input type="checkbox"/>
Height	
Weight	
BMI (and details of any change since accident date)	
Date of accident	
Examination date	
Total time elapsed since date of accident (date of accident to examination date)	Years Months

Brief Accident Details

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Details of dominant/most significant injury sustained (within your expertise)

<p><i>(Include history of condition immediately after accident and in subsequent few days)</i></p>
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Details of other injuries sustained

<p><i>(Include history of condition immediately after accident and in subsequent few days)</i></p>
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Date first treatment sought	
From who was it received?	
Was claimant hospitalised?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If hospitalised where?	
Duration of inpatient stay?	
Total length of absence from work	Years Months From To
If absence is ongoing is it due to the accident?	

Was/is the claimant's absence period reasonable?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Number of GP visits	
Number of Specialist/Consultant visits	
Identity of Specialist/Consultant(s), if known	

Treatment and Investigations to date

<p><i>(Type and name of investigations and results if available i.e. information regarding medications, dosage and changes to same since accident or in e.g. the last six months)</i></p>	
Number of physiotherapy sessions, if any	
<p>X-Ray/MRI results</p> <p><i>(please comment on the results - specifically please indicate if the findings are age related, if it is likely the claimant would have experienced symptoms in any event and if symptoms were activated/aggravated by the accident will they return to pre-accident state and if so when?)</i></p>	

World Health Organisation (WHO) International Classification of Diseases (ICD)
(<https://www.who.int/classifications/icd/en/>)

(Dominant injury code or multiple codes if applicable should be input. All coding should be in the same format as per the following example; S 1 3 . 4 - sprain and strain of cervical spine)

Relevant Medical History (including previous and subsequent accidents and clarification on any interaction of injuries)

Relevant history?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Aggravation of pre-existing condition?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes please give nature of pre-existing condition		
Give details of previous (or subsequent) accident history, if any		
Was pre-existing condition active/symptomatic before the accident?		

Present Complaints to include effects on lifestyle/recreational and domestic personal activities:

Impact on employment	
Interference with quality of life and leisure activities	
Impact on personal relationships	
Visual Analogue Scale (VAS) for pain score	

Clinical Findings on Examination

*(PLEASE INCLUDE **PHOTOGRAPHS** OF ACCIDENT RELATED SCARRING WHERE APPROPRIATE)*

(Range of movement(s))

Clinical Description of effects of Claimant's Illness/Accident/Disablement – practitioners should indicate the degree, if any, to which the claimant's condition is currently affecting his/her ability in the following;

	Normal	Minor	Moderate	Serious	Severe
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning/Intelligence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consciousness/Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance/Co-ordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manual Dexterity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying/Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending/Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Opinion/General Comments and Latest Prognosis

<p>Indicate the degree to which you feel all of the claimant's symptoms/disability have been caused by the accident/event which is the subject of this claim; based on assessment of the injury as described by the claimant the accident/events accounts for (tick one box)</p> <p>1. <input type="checkbox"/> None of the symptoms/disability</p> <p>2. <input type="checkbox"/> A small proportion ($\leq 25\%$) of the symptoms/disability</p> <p>3. <input type="checkbox"/> A moderate proportion (50%) of the symptoms/disability</p> <p>4. <input type="checkbox"/> Most ($\geq 75\%$) of the symptoms/disability</p> <p>5. <input type="checkbox"/> All of the symptoms/disability</p> <p>Please comment further -</p>		
<p>Are further investigations required in respect of any of the injuries sustained in the accident</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p><i>Details of further investigations required?</i></p>		
<p><i>Is the medical intervention and treatment received consistent with the injuries suffered?</i></p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p><i>If the medical intervention and treatment received is not consistent with the injuries suffered, please comment further.</i></p>		
<p><i>If a claimant has a pre-existing condition that is aggravated by an injury, please detail the extent to which the pre-existing injury has been made worse and the duration of any increased symptomology.</i></p>		
<p><i>Estimated total time period from the date of accident in which a substantial recovery took place</i></p>	<p>Years</p>	<p>Months</p>
<p><i>If a substantial recovery has not already taken place, please provide the estimated total time period from the date of accident to substantial recovery</i></p>	<p>Years</p>	<p>Months</p>

Are late complications expected?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If a substantial recovery is not expected please detail the expected prognosis including the likely effects on lifestyle/work		
Are further Specialist reports recommended?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If further Specialist reports are recommended? Please specify the speciality required.		

Anticipated Future Treatment Required

(Include approximate future treatment costs if applicable)

Summary/Additional Information

Completed By

(It is the duty of the completing expert to assist as to matters within his or her field of expertise. This duty overrides any obligation to any party paying the fee of the expert).

Name	
Signature	
Address:	
Qualifications:	
Medical Council Registration number	
Completion Date:	

Please Complete This Section Only if a Claimant has suffered Neck Pain or Whiplash Associated Disorder (WAD)

<i>(Findings as at time of examination)</i>	
Assessment of cervical range of motion – Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	
Palpation for consistent tenderness – Present <input type="checkbox"/> Absent <input type="checkbox"/>	
Neurological signs – Present <input type="checkbox"/> Absent <input type="checkbox"/>	
Following Assessment claimants should be classified according to the Quebec Task Force (QTF) Classification of Grades	
Indicate the Whiplash Associated Disorder (WAD) Grade	
WAD 0	<input type="checkbox"/> (No neck pain, stiffness or any physical signs are noticed)
WAD I	<input type="checkbox"/> (Complaints of neck pain, stiffness/but no physical signs)
WAD II	<input type="checkbox"/> (Neck complaints & decreased range of motion & local tenderness in the neck)
WAD III	<input type="checkbox"/> (Neck complaints & neurological signs)
WAD IV	<input type="checkbox"/> (Neck complaints & fracture, dislocation or injury to the spinal cord)
If the claimant's WAD Grade has changed during the course of their recovery, please comment on these changes:	
Neck Disability Index (NDI) score = ____%	

Neck Disability Index (NDI) and Visual Analogue Scale (VAS) questionnaires (included at the end of the template attached) are to be completed by claimants.

Calculation of NDI scoring is completed by medical practitioners - there are 10 individual sections each with a maximum score of 5. Each section has 6 statements. A single most appropriate statement of the 6 options is chosen for each section. The options are scored in ascending order from 0 – 5 i.e. if the first statement in a section is marked the score for that section = 0, if the last statement is marked the score for that section = 5. Example: 16 = total scored for all sections (of a possible 50 total score for the ten sections) – $16/50 \times 100 =$ (NDI) 32%. If a statement for one or more section is missed or not applicable the score is calculated on the basis of the sections that have been answered e.g. 16 = total scored (of a possible 45 total score for the ten sections when only nine sections have been answered) - $16/45 \times 100 =$ (NDI) 35.5%.

Neck Disability Index (NDI) (to be completed by claimant where there is a neck injury or pain)

Claimant name	
PIAB reference	
Date completed	

This questionnaire has been designed to provide information as to how your neck pain has affected your ability to manage in everyday life. Please **mark in each and every section (1-10) only one box that applies to you**. We realise you may consider that two or more statements in any one section relate to you, but please mark just the box in each section that most closely describes your problem.

Section 1: Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2: Personal Care (washing, dressing, etc.)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but can manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, I wash with difficulty and stay in bed

Section 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

Section 4: Reading

- I can read as much as I want to with no pain in my neck
- I can read as much as I want to with slight pain in my neck
- I can read as much as I want to with moderate pain in my neck
- I cannot read as much as I want to because of moderate pain in my neck
- I can hardly read at all because of severe pain in my neck
- I cannot read at all

Section 5: Headaches

- I have no headaches at all
- I have slight headaches, which occur infrequently
- I have moderate headaches, which come infrequently

- I have moderate headaches, which come frequently
- I have severe headaches, which come frequently
- I have headaches almost all the time

Section 6: Concentration

- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty in concentrating when I want to
- I have a lot of difficulty in concentrating when I want to
- I have a great deal of difficulty in concentrating when I want to
- I cannot concentrate at all

Section 7: Work

- I can do as much work as I want to
- I can only do my usual work, but no more
- I can do most of my usual work, but no more
- I cannot do my usual work
- I can hardly do any work at all
- I cannot do any work at all

Section 8: Driving

- I can drive my car without any neck pain
- I can drive my car as long as I want with slight pain in my neck
- I can drive my car as long as I want with moderate pain in my neck
- I can't drive my car as long as I want because of moderate pain in my neck
- I can hardly drive at all because of severe pain in my neck
- I can't drive my car at all

Section 9: Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hr sleepless)
- My sleep is mildly disturbed (1-2 hrs sleepless)
- My sleep is moderately disturbed (2-3 hrs sleepless)
- My sleep is greatly disturbed (3-5 hrs sleepless)
- My sleep is completely disturbed (5-7 hrs sleepless)

Section 10: Recreation

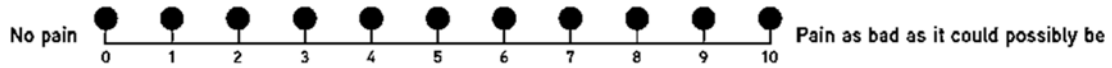
- I am able to engage in all my recreation activities with no neck pain at all
- I am able to engage in all my recreation activities, with some pain in my neck
- I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck
- I am able to engage in a few of my usual recreation activities because of pain in my neck
- I can hardly do any recreation activities because of pain in my neck
- I cannot do any recreation activities at all

Claimant signature: _____ Date: _____

Visual Analogue Scale (VAS) for pain *(to be completed by claimant)*

Claimant name	
PIAB reference	
Date of assessment	

The VAS for pain consists of a 10cm line with two end-points representing 'no pain' and 'pain as bad as it could possibly be'. Claimants are asked to rate their pain by placing a mark on the line corresponding to their current level of pain. The distance along the line from the 'no pain' marker can then be measured giving a pain score out of 10.



Claimant signature: _____ Date: _____