Disability Allowance – Medical Alarm Assessment Form

Work and Income
Te Hiranga Tangata

A service of the Ministry of Social Development

To be completed by a Registered Medical Practitioner

CLIENT NUMBER

Disability Allowance information

To receive a Disability Allowance a person must have a disability and/or personal health need which is:

- likely to continue for at least 6 months, **and**
- have resulted in a reduction of the person's independent function to the extent that the person requires:
  - ongoing support to undertake the normal functions of life, **or**
  - ongoing supervision or treatment by a health practitioner.

Disability Allowance can include the costs of medical alarm rental and monitoring.

A guide for completing this form and some scenarios are on page 3.

Client's details

1. **What is the client's name?**

First name(s) | Surname or family name

2. **What is the client's date of birth?**

Day Month Year

Medical details

3. **Are you the person's usual medical practitioner?**

☐ No ☐ Yes

4. **What is the person's disability?**

5. **Will this disability be likely to last at least 6 months?**

☐ No ☐ Yes

Registered Medical Practitioner's verification

6. **Do you consider that the need for a medical alarm is ongoing and directly related to this client's disability and/or personal health need?**

☐ No ☐ Yes

7. **Is there any other relevant information that should be considered when assessing whether assistance for a medical alarm should be granted?**

☐ No ☐ Yes ▶ Please provide details below:

Registered Medical Practitioner's verification – *continued*

8. **Have you personally consulted with the client?**

☐ Yes ▶ Date of last consultation: Day Month Year

☐ No ▶ Please provide details of why not below:

9. **Have you discussed the information contained in this form with the client and/or their legal representative?**

☐ Yes

☐ No ▶ Please provide details of why not below:

Registered Medical Practitioner's verification

Please print your details below.

HPI number

Medical Practitioner's full name

Practice name and address

Telephone number ( )

Medical Practitioner's signature

Day Month Year

This information is required under the Social Security Act 1964.

Privacy Act: The person has been advised and understands that this information is required for benefit assessment purposes.