Advice to GPs completing DLA and AA factual reports

General
1. Record relevant information only as this will help us and make it much easier for you.
2. Write down facts rather than opinion.
3. Remember your patient may have a copy of the report and read what you have written.

Specific
1. Date seen can also include date seen at hospital if you rarely see the patient.
2. Diagnosis – relevant diagnoses only needed and it is helpful to number the conditions if there are several.
3. Severity – mild, moderate or severe according to numbered conditions at 2. State also if well-controlled if appropriate, eg Diabetes.
4. Variability – this is helpful in very variable conditions, eg 3 courses of Prednisolone in last 12 months.
5. Examination findings – facts are very helpful, such as:
   - Peak flow in asthma and peak flow / spirometry in COPD
   - Length of exercise test in angina (Bruce Protocol)
   - Normal or abnormal joint movements, marked joint swelling
   - Copies of hospital letters if appropriate
6. Medication – level of painkillers and inhalers very useful.
7. Self-care – write what you know, eg rose unaided
8. Ability to get around – write fact not opinion. Good
9. Functionality if known re: self-care and mobility
10. Examination findings. As always, facts are very helpful:
   - Is he/she awareness of dangers? Has he/she got an insight into his problems and surroundings?
   - Is there any confusional states or disorientations or lack of concentrations / motivations etc? Is he/she capable of self medications? If no why not?
   - Is there any H/O psychiatric hospitalisations? If yes were they voluntary or compulsory under mental health acts?
   - Is he/she under secondary care? Who? How often?
   - Medications: type / dose / frequency /how administered / side effects / is it effective
   - Are regular scripts being ordered? If not when was the last prescription issued?
   - Any other supervisory or attention related activity required or given that has been recorded in GP records or hospital letters
   - Any other problems – other than mental health?

5. Epilepsy / I/T/S or loss of consciousness
   - Is there any history of fits or such symptoms?
   - Diagnosis eg Grand Mal (major), petit mal / absence seizures / syncope etc
   - How was the diagnosis made? Is it confirmed by EEG or on history alone?
   - Is he/she under hospital care? Under which specialist? How often seen there? When was he/she last seen?
   - Is there any warning before the fit? Type and how long before it occurs?
   - Frequency of fits as recorded in GP notes and/or as per hospital letters
   - Any injuries recorded after the fits? Any H/O attendance at A&E post fits and resultant falls?
   - Any hospitalisation? Any H/O status epilepticus?
   - Treatment:
     - Medications which? Frequency? Any recent change in medication type or dose?
     - If yes any benefit in control? What?
     - Any future proposed changes in medications planned?
   - Date of last fit as per GP records and / or hospital letters

6. Childhood problems
   - It is very important to remember that when children’s claims are assessed it is based on the facts that the need for attention and / or supervision should be in excess of what one would normally expect in another child of similar age without claimed medical conditions.
   - What we need to know most of the time is:
     - Diagnosis
     - If it is related to behavioural problems eg ADHD / autism / Aspergers syndrome / learning difficulties etc
     - then who made the diagnosis?
     - Is he/she attending a specialist? Which? How often?
     - Is he/she at a normal school or at a special needs school?
     - Is he/she on medications? If yes then is it effective?
     - Are there any reported behavioural problems? If yes give details
     - Any injuries related to the conditions claimed?
     - Any hospitalisations?
     - Any other conditions such as incontinence (if dry before) / any known night time medications such as creams etc
     - Anything else you may consider useful which may be relevant to the claim?