Department for Work & Pensions

If you contact us, use this reference

Office stamp

www.gov.uk

Telephone:

Textphone:

Date:

Employment and Support Allowance

About your patient

Dear Doctor,

If you or someone in your directly employed team has issued a fit note for the above patient, please arrange for that person to complete this form.

Your patient is being assessed for Employment and Support Allowance and we need to find out whether they are able to do any work. By completing this form and providing factual information you will help our Healthcare Professional staff decide whether your patient needs a Work Capability Assessment and if so support that assessment.

Your patient's details

01 **Surname or family name**

02 **Other names in full**

03 **Date of birth**
DD/MM/YYYY

04 **Address**

Postcode

05 **National Insurance (NI) number**

Please note:
- General Practices have a contractual obligation to provide the information requested without charge
- the form should be completed from your medical records. A separate examination is not necessary
- your patient has given consent to allow us to approach you for this information, in accordance with GMC guidelines
- an online version of this report which can be completed electronically and printed is available at **www.gov.uk/government/publications/esa113-interactive-for-use-by-healthcare-practitioners**

More information on completing this form can be found at:
www.communities-ni.gov.uk/publications/guide-completion-medical-factual-reports

You will have received a request for information from the Centre for Health and Disability Assessments. If you are filling this form in online, please ensure all the details are fully completed.

A fully completed form may help inform the Work Capability Assessment or may mean that your patient will not need a further assessment. It will also help us to make a more informed decision on benefit entitlement.

Computer printouts

You can send us a computer printout of the appropriate part of the patient record if you wish, but you will still have to complete any sections of the form where the answer is not clear from the printout. We are only able to accept information directly relevant to our enquiries. If a printout is available, please make sure it includes the following:
- active problems
- current medication with the last prescribed date
- details of the last 3 consultations. Please remove any third party data.

If you have any queries about this form, please phone the number on the letter we sent you in the post.

If you would like to discuss anything with our medical staff, please phone the number above and ask for a member of the medical staff on the customer service desk.

If there is any medical evidence that you think would be harmful to your patient's health, please give us this information on a separate sheet of paper so that this can be withheld.

Please reply within 5 working days. A business reply envelope is enclosed for your use.

Thank you for your help.

Yours sincerely

Office manager

Your reply

Please complete all 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:

About your patient

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 **question 16.**

Patient details

06 **Surname or family name**

07 **Other names in full**

08 **Date of birth**
DD/MM/YYYY

09 **National Insurance (NI) number**

10 **When did your patient last see a GP?**
DD/MM/YYYY

Current conditions affecting ability to work

11 **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

If you need more space to tell us about your patient's conditions, please continue at **question 16**.

Current conditions not affecting ability to work

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

13 **If known from 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 or moving
- ☐ Transferring between seats
- ☐ Reaching
- ☐ Picking up objects
- ☐ Manual dexterity
- ☐ Communicating with others
- ☐ Continence
- ☐ Learning simple tasks
- ☐ Awareness of hazards
- ☐ Initiating and completing personal actions
- ☐ Coping with changes or social engagement
- ☐ Appropriateness of behaviour
- ☐ Eating or drinking

Explanation

14 **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 at **question 16**.

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

- ☐ No

Please tell us why at **question 16**

- ☐ Yes

16 **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.

17 **Your signature**

18 **Your name**

In capitals,

19 **Your profession**

20 **Date**

DD/MM/YYYY

21 **Practice stamp**