

Doctors Name.
Surgery Address.

Your Name.
Your Address.

Date.

I have had a decision on my claim for Disability Living Allowance, and I am in the process of challenging this decision.

Understandably a lot of weight is given to medical opinion and to be successful I will need supportive medical evidence regarding my condition and how it affects me.

The attached is a pro forma on which I have indicated how I am affected. I have been advised to seek confirmation of these statements from you.

If you feel that you do not have detailed knowledge of my abilities to do these tasks, please consider whether my statements are consistent with my condition/s and whether the areas I have listed are likely to be problematic for me.

Thank-you for your time, any support that you can provide will be greatly appreciated.

Yours sincerely,

Name:
Address:
N.I. No:

Please can you confirm all of my illnesses and disabilities?

.....
.....

Mobility

I have stated that the effort of walking more thanyards/metres is dangerous to my health and/or likely to cause long-term deterioration. It would helpful if you could say whether you agree with this.

Agree / Do not agree. Signed.....

‘Severe discomfort’ has been held to include factors such as pain, breathlessness, fatigue and unease of all kinds caused by the physical activity of walking.

I have stated that I can walk approximately.....yards/metres before I feel severe discomfort due to my condition. It would be helpful if you could say whether you agree with this.

Agree / Do not agree. Signed.....

I have stated that although I can walk I need someone with me when I am outside in places unfamiliar to me to guide me or supervise me because of my sight/hearing/mental health problems/other (please state).....

It would be helpful if you could say whether you agree this.

Agree / Do not agree. Signed.....

Practitioner’s Signature:.....

Date:

Please state whether GP, consultant, other:.....

Surgery Stamp/Address

Name:
Address:
N.I. No:

Care

The care component is awarded on the basis of a reasonable requirement for help with personal care tasks. It is not necessary for a claimant to be **unable** to do a task, but rather that they find such difficulty with it as to make their desire for help reasonable.

Because of my illnesses/disabilities, I reasonably require motivation/ Encouragement/physical help with tasks numbered	
Please can you indicate whether you agree or feel that it is consistent with my condition that this would be the case?	
1. Getting out of bed in the morning	Agree / Disagree
2. Getting out of a chair	Agree / Disagree
3. Getting dressed/undressed	Agree / Disagree
4. Having a bath/shower	Agree / Disagree
5. Eating	Agree / Disagree
6. Taking medication	Agree / Disagree
7. Moving around the house	Agree / Disagree
8. Going up & down stairs	Agree / Disagree
9. Using the toilet	Agree / Disagree
10. Sleeping comfortably	Agree / Disagree
11. Getting out of bed during the night	Agree / Disagree
12. Preparing and cooking a main meal for myself	Agree / Disagree
13. I suffer from dizziness/risk of falls/ falling	Agree / Disagree

Please state whether GP, consultant, other:.....
Surgery Stamp/Address

Practitioner's Signature:.....

Date:

Please state whether GP, consultant, other:.....
Surgery Stamp/Address

Name:
Address:
N.I. No:

Care:

The care component is awarded on the need for supervision most of the time in order to prevent substantial danger to self or others. The term substantial danger should not be too narrowly construed, and all the risks and dangers need to be taken into account. It is not necessary for the claimant to receive supervision; it is **the need** for it that counts.

Because of my illnesses/disabilities, I reasonably require supervision/
Watching for the following reasons:

- | | |
|--|------------------|
| 1. Encouragement to mobilize | Agree / Disagree |
| 2. Shortness of breath / angina | Agree / Disagree |
| 3. Numbness in hands/legs/feet / muscle weakness | Agree / Disagree |
| 4. Monitor level of depression / anxiety | Agree / Disagree |
| 5. Danger of falling / Injury (balance) | Agree / Disagree |
| 6. Ensure medication / Adherence | Agree / Disagree |
| 7. Dizzy spells | Agree / Disagree |

Please can you indicate whether you agree, or feel that it is consistent with my condition that the above are areas causing a need for supervision in my case?

Practitioner's Signature:.....

Date:

Please state whether GP, consultant, other:.....

Surgery Stamp/Address