

To

Dr

From

About the visit (for completion by Medical Services)

Please arrange an EMP report for the customer named below.

Please return the completed report by / /

Signature

Name

Date

/ /

Customer's Name

Customer's National Insurance Number

--	--	--	--	--	--	--	--

■ **To the Examining Medical Practitioner**

The Decision Maker deciding entitlement to this claim has requested further evidence. Please complete the medical examination form.

Please give reasons for your opinions.

I was unable to complete the EMP report because:

Information you may need to be aware of

■ **About the visit**

Date of aborted visits

1st aborted visit

2nd aborted visit

Reason why visit was aborted

Signature

Date

Name

Telephone number

To ensure compliance with 'Rehabilitation of Offenders Act 1974' and 'Data Protection Act 1998', your report should not contain any reference to criminal convictions, whether spent or not, unless the information is directly relevant to the customer's condition or disability.

Time examination started

Section 1

1. List all diagnoses either previously diagnosed or found during examination.

Main disabling condition(s)

SPECIMEN

Other diagnoses or medical condition(s)

2. Summary of medical history of the relevant disabling conditions with dates, and relevant details of special tests, investigations and hospital attendance (include inpatient and outpatient).

SPECIMEN

3. Medication

Name	Dose	Reason for use

4. Side effects of the medication

Side effects of the medication reported by the customer

Please comment on the relevance of any side effects to the disabling condition(s)

5. Other therapy

e.g. Physiotherapy, osteopathy and nature of treatment given	Date last given

6. Describe the customer's reported impairments and functional restrictions including response to current treatment

SPECIMEN

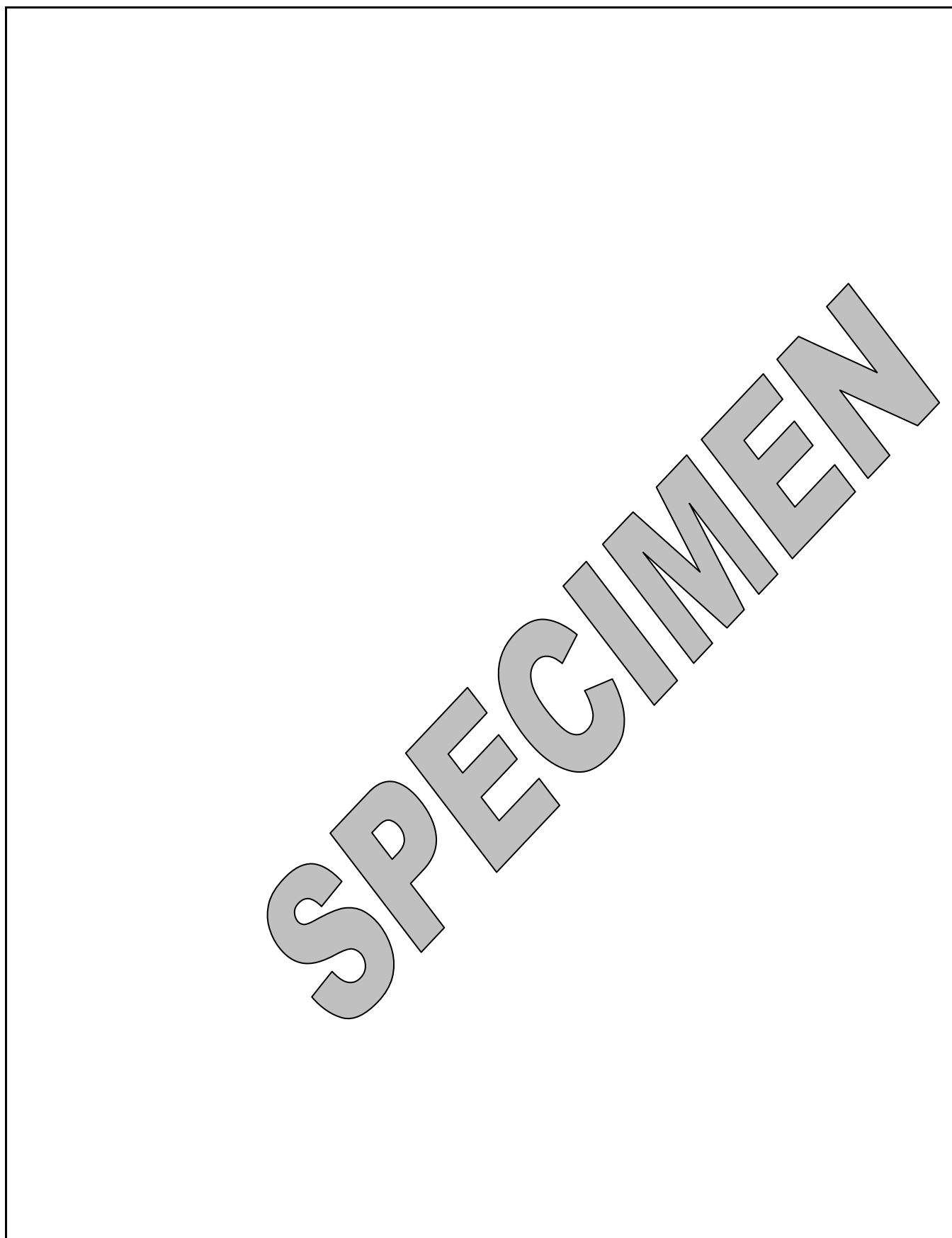
7. Provide an account (over the next 2 pages) of how the customer spends a typical day, consider the activities indicated in the margin and include both day and night*. In addition describe hobbies, interests, leisure pursuits and any relevant social/domestic factors including activities connected to religious beliefs, where help with those activities is needed.

- getting up
- washing, dressing
- using the toilet/continence
- help with medication and other treatments
- rising from a chair
- preparation of food and eating
- going to bed
- help needed during the night e.g. toilet and medication
- ability to walk indoors and out of doors/use a wheelchair
- falls – nature, indoors or outdoors
- need for supervision e.g. to avoid dangers, self-neglect, etc.
- getting around out of doors (including supervision)
- role of carers
- communications with others (including interpretation of sign language, help when visiting people or places, special equipment e.g. writing pad, textphone, special computer etc.)

SPECIMEN

*Night means the time the household closes down at the end of the day

7. Account of a typical day continued



8. Contenance

Does the customer report that they suffer from incontinence?

	By day		By night	
Bladder	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Bowel	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>

9. Describe any incontinence aids used

10. How often does the customer report that they need help to use the toilet at night?
Complete the boxes below:

Number of times a night	<input type="text"/>
Time taken on each occasion (in minutes)	<input type="text"/>
Nights a week	<input type="text"/>

11. Accommodation

Describe any features of the current accommodation that cause increased problems for the customer e.g. upstairs toilet, steep steps. Please note details of any responsibility that the customer has for **children**.

12. Variability

Describe any fluctuation in the condition(s) as described by the **customer**. Include frequency, duration and severity of any variations. Give a brief description of good and bad days.

SPECIMEN

Section 2 – Clinical Findings

1. General Clinical Appearance

2. Mental state

Give an overview of the customer's mental state. Illustrate your answer by reference to simple tests of cognitive function if applicable.

3. Vision

Including visual acuities for near and distance vision.

4. Hearing

Describe any hearing impairment present.

Would the customer be able to understand a shout at one metre in a busy street?

Yes No

5. Examination of heart and chest (including peak flow) where relevant

Large empty box for examination notes, overlaid with a large diagonal watermark reading "SPECIMEN".

6. Is the customer right or left handed?

Right Left

7. Upper and Lower Limb Function

Indicate Limb Function 1, 2, 3 or 4

- Function 1 = Full function
- 2 = Slight impairment
- 3 = Substantial impairment
- 4 = Nil function

RIGHT

Hand	Wrist	Forearm
Elbow	Upper arm	Shoulder

Foot	Ankle	Lower leg
Knee	Thigh	Hip

LEFT

Hand	Wrist	Forearm
Elbow	Upper arm	Shoulder

Foot	Ankle	Lower leg
Knee	Thigh	Hip

Please complete, where relevant, physical examination findings (joint-deformity, range of movements, power, tone, reflexes, weakness, wasting, sensation) indicating clinical reasons for loss of function.

SPECIMEN

8. Spinal Function

Indicate Spinal Function 1, 2, 3 or 4

- Function 1 = Full function
- 2 = Slight impairment
- 3 = Substantial impairment
- 4 = Nil function

Cervical

Thoracic

Lumbar

Please complete clinical findings where relevant

9. Any other relevant neurological findings including CNS, gait and balance

Empty box for additional neurological findings.

10. Other systems where relevant e.g. skin, abdomen, reticuloendothelial system

Empty text box for section 10. A large, light gray watermark reading "SPECIMEN" is diagonally overlaid across the box.

11. Summary of informal observations (observed behaviour)

Empty text box for section 11. A large, light gray watermark reading "SPECIMEN" is diagonally overlaid across the box.

Section 3

Your comments throughout Section 3 relate to **your opinion** regarding the customer's functional limitations and should be justified with reference to clinical findings, observed behaviour and activities of daily living etc. Account should be taken of factors such as pain, fatigue, breathlessness, variability, the ability to carry out tasks safely, reliability, repeatedly and at a reasonable speed.

Detailed justification is necessary in those areas where the requirement for attention and/or supervision is different i.e. more or less, than that described by the person or their carer. Comment on any areas where the requirement for attention/supervision is different from that described by customer/carers.

1. Summary of functional ability

Evaluate the customer's account of their functional ability in the light of the clinical findings (giving clinical reasons e.g. inflammation, pain, paralysis), observations and activities taking into account the factors listed above. In addition, use details in Sections 1 and 2 to support **your opinion** as to whether the condition is likely to vary and to what extent.

Physical
Mental
Variability

Mobility

2. In your opinion does the medical evidence show that there is a physical condition that renders the customer unable to walk?

Yes – Please complete question 4

No – Go to question 3

3. In your opinion does the medical evidence show that there is a physical condition that restricts the customer in their ability to walk outdoors on level ground?

Yes

No

Please comment on

Gait
Balance
Use of walking aids or prostheses
Discomfort, pain, breathlessness on walking
Likely speed of walking (normal speed 90 metres/minute or 1 ½ metres/second)
Need to halt, reason for and likely duration of halts
Likely distance before onset of severe discomfort

NOW PLEASE COMPLETE QUESTION 4.

4. Evidence to support your opinion on ability to walk

Evaluate the customer's account of their ability or inability to walk in the light of the clinical history, examination, observed behaviour and the effects of the medical condition(s) on daily living.

--

5. Guidance or supervision out of doors on unfamiliar routes

Describe what help would be required while walking outdoors most of the time. Please give your reasons.

Physical factors including sensory impairment
Mental health factors

6. In section 1 has the customer reported any falls or tendency to fall?

Yes – Please comment below

No – Go to question 7

If yes, taking into account all the clinical evidence, in your opinion are there any features of the medical condition(s), which would put the customer at risk from falls.

SPECIMEN

7. Attention

In your opinion does the evidence show that the customer can safely: *(tick appropriate box)*

	Without someone's help	Only with someone's help	Medical evidence to support opinion including any limb and spinal impairment identified at questions 6, 7, 8 and 9 in section 2*
Upper limbs/cervical spine			
Wash/shave/clean teeth			
Cut up food			
Eat			
Drink			
Peel/chop vegetables			
Use taps			
Cope with hot pans			
Lower limbs/lumbar spine			
Walk on level indoors			
Upper and lower limbs/spine			
Turn in bed			
Get out of bed			
Rise from usual chair			
Use stairs			
Dress			
Undress			
Take a bath or shower			
Get to the toilet			
Cope alone at toilet			
Use traditional cooker			
Get in/out of wheelchair			
Get about in a wheelchair			

*Detailed justification is necessary for those areas where requirements for attention differ from those reported by the customer/carer.

8. Describe any aids that are used and any difficulties, which might limit their use. Specify any aids that could be used if available. Please give your reasons.

9. Medication, other treatments and monitoring of the medical condition.

Does the medical evidence show that the customer needs help or supervision with the above?

 Yes No

Give details and reasons to support your opinion

10. Continence

In your opinion is the customer's medical condition(s) likely to cause incontinence (consider urinary and faecal incontinence)?

 Yes No (go to question 12)

Give details and reasons to support your opinion

11. Can the customer cope independently with their incontinence problem?

Yes

No

If not, what type of attention is needed, how often and for how long?
Give details of any aids used.

By day:

By night:

12. Help with the toilet

Could a urine bottle (males only) be used unaided either by day or night?

Yes

No

Please give your reasons

13. Could a commode be used unaided either by day or night?

Yes

No

If no, please give reasons

Take into account personal and domestic circumstances (such as availability of commodes and the home environment).

14. At section 1 question 10, did the customer report that he/she needed help to use the toilet at night?

Yes

No (go to question 15)

If yes, in your opinion, does the clinical condition lead to a need for this level of help/attention at night? Please give your reasons.

15. Communication

Does the customer have any difficulty in communicating?

Yes

No (go to question 16)

Describe any help required from a third party and give reasons.

Mental health, learning disabilities and cognitive impairment

Please complete the following. Give reasons for your opinions taking into account your clinical findings, observed behaviour and daily activities as described in the summary of functional ability at section 3, part 1.

16. Does he/she suffer from any mental disablement likely to cause him/her to neglect personal hygiene or nutrition?

Yes

No

Please give your reasons

SPECIMEN

17. Is the customer aware of common dangers?

Yes

No

Give examples of dangerous behaviour.

SPECIMEN

18. Does the customer have any tendency to wander – either by day or by night?

Yes

No

Please give details

19. Is the customer destructive to property or to others?

Yes

No

Please give details

SPECIMEN

20. Prognosis of the functional effects of all the main disabling condition(s)

SPECIMEN

21. Please add any further information that you think would aid the Decision Maker

SPECIMEN

EPILEPSY QUESTIONNAIRE

To be completed if requested by Decision Maker or if found to be clinically relevant at assessment.

1. Diagnosis of type(s) of epilepsy.

2. Description of seizures including details of any warning or aura.

3. Frequency of seizures – by day and/or by night. Indicate if seizures predictable.

4. History of status epilepticus or any clusters of seizures over the last three years.

SPECIMEN

5. History of any injuries, other than minor, resulting from seizures, with dates, in the last three years.

6. History of any automatic or potentially dangerous behaviour related to seizures.

7. Overview of disabling effects of the seizures including control of the condition. Include any other relevant information that may help the Decision Maker. Give reasons for your opinions.

SPECIMEN

This form has been completed by a doctor approved by the Secretary of State of the Department for Work and Pensions.

I have completed this form in accordance with the current guidance to Examining Medical Practitioners.

I have also understood that the only information that can be withheld is medical evidence that would be harmful to the person's health. I have stated any medical evidence I think may be harmful to the person's health in the section of this report headed "Harmful Information – do not copy".

Time examination ended

Additional time to complete the report

Doctor's name

Date

Doctor's signature

SPECIMEN



SPECIMEN

Harmful Information – do not copy

Please ensure that everything written on this page is of such a nature that, if disclosed to the customer, it would be medically harmful to their health. You must not write anything here that is other wise confidential or potentially embarrassing to either the customer or the author.

SPECIMEN