Advice to GPs completing Disability Living Allowance and Attendance Allowance Factual Reports

Contents

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.
4. Your report should be based upon your knowledge of the patient and the medical records. It is not necessary to interview the patient, as any information they provide, especially with regard to mobility and self care may not necessarily be objective.

Specific

1. Date you last saw the patient. If no recent contact with patient please include where and when seen by other health care professional if relevant in your report.
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, e.g. Diabetes.
4. Variability – this is helpful in very variable conditions, e.g. 3 courses of prednisolone in last 12 months.
5. Examination findings – facts are very helpful, such as:
   - Peak flow/spirometry in asthma or COPD
   - Results of exercise test in angina (Bruce Protocol)
   - Normal or abnormal joint movements, extent of any joint swelling/deformity.
   - Summary of any relevant information in hospital letters
6. Medication – level of painkillers and inhalers very useful
7. Self-care – write what you know, e.g. rose unaided from a chair in the surgery, no bending difficulty noted, had an OT assessment recently.
8. Ability to get around – write fact not opinion. Good examples would be:
   - Walks slowly with marked right-sided limp using walking stick
   - Not breathless or very breathless when attends surgery for routine check
   - Normal balance and gait on (date).
9. Conclusion – this section is not asking for an opinion but rather to add something relevant, e.g. in severe depression has suicidal ideas or psychotic features. If there is treatment planned such as a hip replacement this is useful information here.

GPFR examples for specific conditions

1. Asthma / COPD / other respiratory conditions

- Diagnosis? Any other associated conditions?
- **Severity? Whether mild moderate or severe?**
- Symptoms: whether breathlessness at rest /mild exertion such as talking / or on moderate exertion?
- Is he/she under hospital care? Details if possible
- Clinical findings such as:
  Chest examination
  PEFR: Expected
  Most recent PEFR
  Is there any variations from previous recordings?
  Lowest recorded PEFR when? Etc.
- **Spirometry** results if available
- Treatment:
  Inhalers Which inhalers
  Are inhalers regularly requested? If not
  When was the last script?
  Nebulisers and or oxygen used at home?
  Oral steroid courses in the last 6 to 12 months
  Is there a history of hospitalisation for acute attack?
- Functional ability if known re: selfcare and mobility

2. Ischaemic heart disease

- Diagnosis and any other associated conditions?
- **Severity whether it is mild / moderate or severe?**
- Symptoms
  Anginal attacks
  How frequent?
  When do they occur i.e. **are they associated with mild, moderate or severe exertion?**
  Does GTN help?
  Shortness of breath
  Is it present?
  Is it on mild, moderate or severe exertion?
  Is there any evidence of heart failure?
- Is he/she under hospital care?
- Is there any history of repeated attendance at A&E or inpatient admissions due to chest pain?

- How was diagnosis of IHD made? Was it only clinical or on investigations? What investigations? Results of the investigations such as ECG / ECHO / exercise test (Bruce Protocol)
- Treatment
  Medications / dose / frequency
  Are prescriptions regularly ordered?
  Are they effective?
  Has he/she had any surgical treatment or any planned in future for IHD? If yes which procedure?
- Functional ability re self care and mobility (if known)

3. Musculoskeletal conditions such as arthritis / back pain etc

- Diagnosis: If arthritis type such as OA / rheumatoid etc
  If back pain – is it mechanical or prolapsed disc, etc
- Symptoms and clinical findings that are recorded in GP records and or in hospital letters
  Important for us is:
  For arthritis**:** Which joints affected?
  Severity of affected joints?
  Any deformity?
  Any other clinical findings?
  Exacerbations and flare ups / how often & how bad?
  For backache**:** Pain / variability / duration of acute exacerbations and **severity**
  Is there any radiation of pain?
  Is there any neurological deficit or muscle wasting?
  Range of movements of spine / SLR
- Results of important investigations such as MRI scan
- Hospital treatment: any
  Physio?
  Occupational therapist? Any aids provided?
  Back pain clinic attendance?
  Counselling / clinical psychologist?
  Neurologist or rheumatologist attendance?
  Has any of above helped?
- **Any planned future surgical treatment? Such as: is he/she waiting for hip or knee replacement? If so when referred to hospital?**
- **Medications: What? Dose? Frequency? Are regular scripts ordered? Does medications help pain etc?**
- Is there any history of falls recorded? If yes any hospital attendance?
- Any aids used?
- Functional effects on self care and mobility (if known)

4. Mental health conditions

- Diagnosis
- How long these conditions present?
- **Severity is it mild, moderate or severe?**
- Day to day variations reported to GP or any other health professionals (if known)
- Any recorded history of suicidal thoughts / intent / attempts in the past? If yes when? How?
- Any self harm episodes?
- Is there or has there been any history of self neglect?
- Is he/she aware of dangers? Has he/she got an insight into his problems and surroundings?
- Is there any confusional state or disorientation or lack of concentration / motivation etc? Is he/she capable of self medicating? If no, why not?
- Is there any history of 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 or loss of consciousness

- Is there any history of fits or such symptoms?
- Diagnosis e.g. Grand Mal (major), petit mal / absence siezures / 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 history of attendance at A&E post fits and resultant falls?
- Any hospitalisation? Any history of 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**
- Any other associated other conditions e.g. mental health?

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 e.g. 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?