

Dr Uppual  
Leysdown Surgery  
36 Leysdown Road  
Leysdown-on-Sea  
SHEERNESS  
Kent  
ME12 4RE

36600

**Our address:** Independent Assessment  
Services  
c/o DWP PIP(1)  
Mail Handling Site A  
Wolverhampton  
WV98 1AA

**Telephone:** 0118 914 9400

**Our Ref:** NR518365D

**Date:** 16th September 2020

## PERSONAL INDEPENDENCE PAYMENT

### Request for Further Medical Evidence

Dear Doctor,

I am writing to you about a patient who has made a claim for Personal Independence Payment:

Patient's name: **Miss KATRINA MARGERY**

Date of birth: **24/05/1967**

Address: **FLAT 1, WING HOUSE, WING RD, LEYSDOWN-ON-SEA, SHEERNESS,  
SHEERNESS, KENT, ME12 4QR**

Independent Assessment Services is contracted to carry out assessments for Personal Independence Payment by the Department for Work and Pensions. It would be very helpful in assessing your patient's benefit claim if you could complete the enclosed factual report form. **Your patient (or a person appointed to handle their affairs due to the claimant's mental incapacity to do so) has given their consent for us to request this information from you.**

When completing your report, please provide information on the following key areas:

- Can you please confirm this lady's medical conditions, current medications and advise of any specialist input.
- Please advise on her ability to self care and mobilise. Please advise of any significant limb restrictions. Many thanks

You should base your report on your knowledge of the patient and on her records. A special appointment is not required. Please include in your report any relevant information contained in letters or reports from hospitals or consultants. It may be helpful to your patient to enclose any relevant correspondence contained in their file, such as recent consultant letters or letters from a Community Mental Health Team. If the patient has died or recently moved to another area please still complete the report if you can.

29 SEP 2020

29 SEP 2020



To ensure compliance with the Rehabilitation of Offenders Act 1974 your report should not contain any reference to criminal convictions, whether spent or not, unless the information is directly relevant to your patient's condition or disability. This report is not subject to the Access to Medical Reports Act 1998. The patient does not need to read it before it is returned.

The patient may, at any stage, request a copy of this report to be sent to them by the Department for Work and Pensions. Harmful and embarrassing information should not be included in your report.

Guidance on completing section 6 is enclosed. Further information including more detailed guidance on completing your report can be found at [www.dwp.gov.uk/healthcare-professional/guidance](http://www.dwp.gov.uk/healthcare-professional/guidance).

We enclose an invoice for you to claim a fee of £33.50. Please send your completed report and invoice together\* in the enclosed business reply envelope. **Please reply within 5 working days.**

\*A request for payment will only be accepted on the enclosed invoice form, which must be completed and include the GMC number.

If you have any queries regarding completion of the report or if you would like to discuss this request with our medical staff, please phone the number at the top of this letter. Thank you for your help.

Yours sincerely,

**Ms Lindsay M Burns** (Nurse, 83B1019E)



# Your GP Factual Report

901266015

Patient's name & Ref No Miss KATRINA MARGERY

NR518365D

Date when patient last seen by a health professional

25/ 9 / 2020

Where and by whom

TELEPHONE CONSULTATION WITH DR T. OJUNAWO  
HARD LAD FOR PAST 18 MONTHS

## Notes:

- Please record relevant information based on your knowledge of the patient and their medical records.
- Please write down facts rather than opinion. We require an objective report - please only include information about symptoms that are recorded in the patient's records and information about disabling effects that you or another healthcare professional have directly observed.
- It may be helpful to your patient to enclose any relevant correspondence contained in their file - for example, recent consultant letters or letters from a Community Mental Health Team. Please ensure that any third party information is removed. Third party information is any sensitive information that refers to someone other than the patient - for example, the patient's family
- Please complete all sections as fully as possible but write "not known" if appropriate. "Not known" can be helpful.
- Relevant information is anything that relates to health conditions or disabilities which impact on the patient's functional ability.

## 1. Disabling conditions

Please list conditions or impairments which affect the patient's functional ability.

25.9.2020 HARD IS HARD AND HAS BEEN SO FOR PAST 18 MONTHS  
SHE USED TO BE ON MERTICAN WHICH SHE LAST HAD PRESCRIBED  
BY US 3 MONTHS AGO. SHE STOPPED THIS AS IT WAS MAKING HER  
FEEL ZAMBED. SHE ALSO ADMITS TO POOR SLEEP, POOR APPETITE  
LACK OF MOTIVATION AND FATIGUE. SHE ADMITS TO SUICIDAL THOUGHTS  
IN THE PAST - BUT LESS FREQUENT NOW.

## 2. History of condition(s). Include details of any relevant special investigations

25.9.20. r. MIXED ANXIETY AND DEPRESSIVE DISORDER  
ALCOHOL INTAKE 24 UNITS A WEEK. SMOKES 5 CIGARETTES A DAY  
BLOODS REQUESTED AND PATIENT REFERRED TO COUNSELLING.

24.4.2003 PATIENT HAS ASTHMA

### 3. Symptoms and variability

**3. Symptoms and variability**  
This is especially helpful in conditions that fluctuate. It should be based on information in the clinical record. Include both day-to-day and longer-term fluctuations. Include the frequency and duration of exacerbations. Please also specify if the condition is well controlled.

specify if the condition is well controlled.

#### 4. Relevant clinical findings

**4. Relevant clinical findings**  
*Entitlement is based on the impact of the individual's impairment or health condition(s) on their everyday life. Please provide details of examination findings related to the severity or impact of any health conditions or impairments.*

impairments.

## 5. Treatment - Current, planned, response and prognosis

Please provide details of drug and non-drug treatment and aids and appliances used (prescribed or, if known, non-prescribed). Please specify frequency of treatment and, for medication, dose as relevant.

25.9.2020 CITALOPRAM 20mg once daily

## 6. Effects of the disabling condition(s) on day to day life

If known, it would be helpful to have information on the patient's ability to:

- Manage their health conditions and treatment
- Communicate
- Walk or move around
- Get somewhere on their own
- Make simple decisions
- Prepare, cook and eat food
- Wash, bathe and use the toilet/ manage incontinence
- Dress and undress

Only include information that has been confirmed by a health professional. Please state if this is not known.

7. Does the patient have a history of threatening or violent behaviour?

No ☒ Yes ☐ Don't know ☐

If yes, tell us about their behaviour within the last 5 years. Use the space below at Part 9

8. Could your patient travel to an assessment centre by public transport or taxi?

Yes ☐ No ☐ Don't know ☒

If no, please tell us why. Use the space below at Part 9

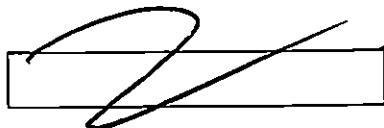
9. Additional information

Use this section if there was insufficient space in one of the previous boxes OR to add important relevant factual information that has not been written in the body of the report. Do not use the section to provide an opinion.

PLEASE SEE ATTACHED PATIENT SUMMARY

I understand that, in certain circumstances, this report will be released to my patient, their legal representative and any authority deciding an appeal in relation to their entitlement to benefit. I also understand that the only information that can be withheld is medical evidence that would be harmful to the person's health.

Your signature



Name in capitals

DR. T. OGUNNOWA

Date

5 11 01 20

Stamp

ST GEORGES MEDICAL CENTRE  
55 ST GEORGES AVENUE  
SHEERNESS, KENT ME12 1QU  
TEL: 01795 582880  
FAX: 01795 663221

## Guidance on completion of section 6

The assessment for Personal Independence Payment considers the claimant's ability to carry out a series of everyday activities as per section 6.

In this section, please provide information on the claimant's ability to carry out the relevant activities, if you are able.

Write what has been observed by yourself or another healthcare professional in relation to these listed activities. For example: self-care - "rose unaided from a chair in surgery, no bending difficulty noted"; getting around - "walks slowly with marked right sided limp using a walking stick, not breathless or very breathless when attends surgery for routine check".

Please only include observations, not opinions.

### To consider when completing the form:

Here are **examples of information** that is particularly useful to us for the following conditions.

- **Respiratory conditions** including asthma and COPD - exercise tolerance, **recorded** variability, peak flow readings (including serial readings), spirometry results, treatment and compliance - prescriptions requested regularly / when was last prescription, oral steroids and hospital admissions in last 12 months.
- **Ischaemic Heart Disease** - investigations including results of formal exercise testing, exercise tolerance, clinical findings, response to treatment including nitrates, treatment compliance, hospital admissions in last 12 months.
- **Musculoskeletal conditions** - **recorded** symptoms, recorded history of falls, detailed clinical findings **including range of joint movements**, treatment including planned surgical treatment with dates, response to treatment and compliance - prescriptions requested regularly / when was last prescription.
- **Mental health conditions** - documented history of self-harm, self-neglect, detailed mental state findings, history of admissions - voluntary or compulsory, regular prescriptions and last one ordered.
- **Sensory impairment** - visual and auditory acuity.

