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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, SHELLNESS,
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

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Independent Assessment Services is a trading name of Atos IT Services UK Limited
Atos IT Services UK Limited is registered in England and Wales
Registered Office: Second Floor, MidCity Place, 71 High Holborn, London, WC1V 6EA
Registered No. 01245534. VAT No. GB 232327983

OP101

Providing
assessment
services on
behalf of



Department
for Work &
Pensions

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.

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)

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.



Your GP Factual Report

901266015

Patient's name & Ref No Miss KATRINA MARGERY

NR518365D

Date when patient last seen by a health professional

/ /

Where and by whom

--

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.

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

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.

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

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.

[illegible]

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.

[illegible]

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

-
- This image shows a single sheet of white paper with horizontal blue or grey ruling lines. A solid vertical line runs down the right side of the page, creating a margin. The paper appears to be from a notebook or a standard writing template. There are no markings, text, or drawings on the page.

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.

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

Date

Stamp

GP Factual Report Invoice

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

Related GP Factual Report

GPFR serial no: 901266015
Date requested: 16th September 2020
DWP ref: NR518365D
Patient's name: Miss KATRINA MARGERY
Date of birth: 24/05/1967
GP/surgery invoice ref:

Payee details:

Payee name:

Payee name to be the same as the account holder

Surgery name and address:

Postcode:

VAT status

☐ VAT-registered: VAT no:
☐ Not VAT registered: Total amount: £33.50

NET amount: £33.50
VAT 20%: £6.70
Total amount: £40.20

Bank Details (Payment will be made by BACS transfer)

Sort code:

Account no:

I hereby claim the appropriate fee for completing the above GP factual report

Print name: Tel no:

Signature: Date:

GMC no. of the GP who completed the GPFR (must be completed):

Authorisation (ATOS USE ONLY) WBS: GB.704471.020.06

GL code: 604102

Print name:

GPFR received:

Signature:

Payment Approved: