

## Employment and Support Allowance

Practice Manager  
ST. GEORGE'S MEDICAL CENTRE  
55 ST. GEORGES AVENUE  
SHEERNESS  
ME12 1QU

36600/64

40230

Our phone number is: 0208795 8761

If you have a textphone,  
you can call on: 18001 0208795 8761

If you get in touch with us, tell us this  
reference number: NR518365D

Date: 25th January 2018

## About your patient

Full Name Miss Katrina Margery

NINo NR518365D

Date of birth 24th May 1967

## Address

Flat 1, Wing House, Wing Rd,  
Leysdown-On-Sea, Shellness, Sheerness  
Kent, ME12 4QR

Dear Doctor,

Your patient is being assessed for Employment and Support Allowance and we need to find out whether they are able to do any work. By completing this form and providing factual information you will help our Healthcare Professional staff decide whether your patient needs a face-to-face work capability assessment and if so support that assessment.

Please note

- NHS doctors have a **contractual obligation** to provide the information requested without charge.
- The form should be completed from your medical records. A separate examination is not necessary.
- It is acceptable for you to delegate completion of the form to your practice nurse but you must confirm your authorisation by signing at the end.
- Your patient has given consent to allow us to approach you for this information, in accordance with GMC guidelines.
- An online version of this report which can be completed electronically and printed is available at [www.gov.uk/government/publications/esa113-interactive-for-use-by-healthcare-practitioners](http://www.gov.uk/government/publications/esa113-interactive-for-use-by-healthcare-practitioners)
- **A fully completed form may help inform the face to face work capability assessment or may mean that your patient will not need a further assessment. It will also help us to make a more informed decision on benefit entitlement**

## COMPUTER PRINTOUTS

You can send us a computer printout of the appropriate part of the patient record if you wish, but you will still have to complete any sections of the form where the answer is not clear from the printout. We are only able to accept information directly relevant to our enquiries. If a printout is available, please make sure it includes the following:

- Active problems;
- Current medication with last prescribed date;
- Details of the last three consultations. Please remove any third party data.

If you have any queries about this form please phone the number above. If you would like to discuss anything with our medical staff, please phone the number above and ask for a member of the medical staff on the customer service desk. If there is any medical evidence that you think would be harmful to your patient's health, please give us this information on a separate sheet of paper so that this can be withheld.

**Please reply within 5 working days.** A business reply envelope is enclosed for your use.

Thank you for your help.

Yours sincerely,

Mr Ian Tuveri-Ellis

**Miss Katrina Margery**

NR518365D

24.05.1967

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Freepost RTGB-JXCY-XXRT  
Centre for Health and Disability Assessments  
Wembley ASC  
Mail Handling Site A  
Wolverhampton  
WV98 1SJ

Please answer the following questions from the information which is currently available to you.

If you need more space for any of your answers, please continue at Part 7.

**1 When did your patient last see a GP?**

17/1/18

**2 Current conditions affecting ability to work:**

Please give us details of those conditions **which may have significant effect on the person's capacity to work.** Include:

- Relevant symptoms and signs, including side effects of medication, with dates. For mental health conditions, please provide brief mental state examination findings, if available.
- Past, present and planned investigations and management, including medication, **where relevant.**

If you are sending a computerised printout of current medication you do not need to list this here.

Please complete **both sides** of this form.

**and return the completed form in the supplied envelope - with the above address showing in the window**



# About your patient - continued

NINo: NR518365D

## 3 Current conditions not affecting ability to work

Please list any other relevant conditions that do not affect the ability to work.

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## 4 If known from your knowledge of the patient, please tick the boxes that apply and provide a brief explanation if your patient has difficulties with any of the following activities

- Walking or moving ☒
- Transferring between seats ☐
- Reaching ☐
- Picking up objects ☐
- Manual dexterity ☐
- Communicating with others ☐
- Continence ☐
- Learning simple tasks ☐
- Awareness of hazards ☐
- Initiating and completing personal actions ☐
- Coping with changes or social engagement ☐
- Appropriateness of behaviour ☐
- Eating or drinking ☐

*Pain in both feet.*

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## 5 Does the patient have a history of threatening or violent behaviour?

No ☐Yes ☐

Tell us about their behaviour within the last 5 years, and whether they have been identified by the Zero Tolerance (Violent Behaviour) Initiative. Use the space below at Part 7

## 6 Could your patient travel to an examination centre by public transport or taxi?

No ☐Yes ☐

Please tell us why at Part 7

*unknown*

## 7 Additional information

Please continue on a separate sheet if necessary.

*Has had painful feet for past 2 years - Plantar fasciitis also suffering from hair loss due to stress, referred to orthotics. Has suffered from this in the past*

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The information you have given us may be copied to the patient, their legal representative or the Tribunal Service.

## Your Signature

Signature

*[Signature]*

Name IN CAPITALS

Dr A. DADA

Date

29 / 1 / 18

## Practice stamp

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