Doctor's Report for Disability Living Allowance, Attendance Allowance or Incapacity Benefit to accompany your patient's claim under Special Rules

THIS IS **NOT** A CLAIM FORM

Patient's copy

Surname

Other names

Date of birth / /

Address

Part 1 - Condition

What is the diagnosis?

Other relevant diagnoses?

Date of diagnosis?

/ /

Is the patient aware of their condition and/or prognosis?

YES ☐ NO ☐

If not, please tell us the name and address of their representative

Part 2 - Clinical Features

which indicate a severe progressive condition (For example: rate of progression, recurrence, staging, tumour markers, CD4 count and viral load, bulbar involvement, respiratory and/or heart failure etc.)

Part 3 - Treatment

Please give details of relevant past or current treatment with dates **including response** (if none or palliative please state)

Is any other intervention or treatment planned which may significantly alter progression of the condition?

Declaration: the person named above is my patient. This is a full report of their condition and treatment. I have read and understand the notes on the completion of this form and I am satisfied that the form is appropriate. I am the patient's:

☐ Registered General Practitioner

☐ Hospital or hospice consultant

☐ _____

Signature

Your name

Phone number

Address or FHSA stamp

Date / /

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