



Medical evidence checklist

Medical information for an NDIS application or additional condition

This checklist supports people applying for the NDIS or asking for an additional condition to be considered in their current NDIS plan. Ask your GP or specialist for a letter covering the points below, with relevant medical reports.

Participant: _____

New condition: _____

GP or specialist: _____

1. What is the condition?

- ☐ Name of the condition, when it was diagnosed and who diagnosed it.
- ☐ Examination results, scans or tests that support the diagnosis.
- ☐ How the condition affects the person's body or ability to do things.

2. What treatment has been tried?

- ☐ Past and current treatments: when they started, how long they lasted, and how often they were used. Include medicine doses where relevant.
- ☐ What each treatment helped with, what did not improve and any side effects.
- ☐ Difficulties that remain even after treatment.
- ☐ Treatment, tests or specialist appointments still planned.

See the treatment table on page 2 for the detail required.

3. What is expected in the future?

- ☐ Whether the difficulties caused by the condition are **likely to last throughout the person's life**, and why.
- ☐ Which difficulties are expected to last, even with treatment.
- ☐ Recommended treatment options considered. Could a suitable treatment remove the lasting difficulties, or will some remain?
- ☐ What further treatment could improve, and what the person would still find difficult afterwards.
- ☐ Treatments not tried or ruled out, and why. If the likely outcome is unclear, what needs to happen before the doctor can give an opinion?

"There is no cure" is not enough on its own. The doctor needs to explain which difficulties are expected to last for this person, and why.

Treatment and prognosis

Example treatment table

Prompts and examples only. These are not condition-specific treatment recommendations.

Treatment	Dates / duration	Dose / frequency	Result	Current plan
Medication name	Started [month/year]; used for [duration]	[Dose]; [times per day]	Benefit, remaining difficulties, side effects	Continue, change or stop
Physiotherapy / exercise	[Start-finish dates]	[Sessions per week/month]; home exercise frequency	Change in movement, pain or activity tolerance	Continue, modify or completed
Procedure / surgery	[Date]	Procedure performed	Outcome and restrictions remaining	Follow-up or further procedure
Treatment excluded / not undertaken	[Date considered]	Not applicable	Reason excluded; supporting clinical detail	Alternative or next step

"Has tried medication and physiotherapy" does not show how long treatment was provided or whether it helped.

Best practice and treatments not undertaken

Where available, reference Australian clinical guidelines or best practice frameworks for the condition. Identify the source and date. Explain which recommended treatments have been tried, their outcomes and why they did not resolve the impairment.

Also identify treatments not tried or excluded, with individual clinical reasons: drug interactions, adverse effects, poor previous response, other health conditions, contraindications or access barriers.

Without this explanation, the NDIA may consider treatment options unresolved and permanency insufficiently established. Every treatment does not need to be tried; the clinical reasoning must be clear.



Example medical letter

The practitioner must use their own findings and opinion. This is not wording to sign without clinical verification.

"[Name] has [diagnosis], confirmed by [findings/investigations] on [date]. This causes [specific impairment]."

Treatment has included [treatments, dates and outcomes]. Relevant best practice guidance is [source/date]. Treatments not undertaken include [options and clinical reasons]. Despite treatment, [impairment] remains.

In my clinical opinion, [specified impairment] is likely to be permanent because [clinical reasons].

Further treatment includes [plan]. It is expected to improve [symptoms or function]. Despite this improvement, [specified impairment and functional restrictions] are expected to remain because [clinical reasons]. [Explain whether any appropriate, available treatment is likely to remedy the impairment]."

Final check: Dated, signed letter identifying the practitioner and qualifications. Existing reports can be used, with an update where treatment or prognosis needs current confirmation.

Improvement can occur alongside permanent impairment

The person does not need to prove that no further improvement is possible. Treatment can improve symptoms, strength or task performance while lasting impairment remains. The medical letter should explain whether appropriate treatment is expected to remedy the impairment, and which impairments and functional restrictions are expected to remain despite improvement.

Where clinically supported, explain why expected improvement will not remove the substantial functional restrictions or ongoing assistance needs. OT evidence then describes the remaining effect on everyday activities and support required.

NDIA guidance: [How to help your patient access the NDIS • Disability requirements](#)

This checklist supports evidence collection. It does not guarantee NDIA acceptance or funding.

Before an access assessment or application

NDIS access requires clear medical evidence about your impairment and treatment history.

If further treatment could affect eligibility, we strongly recommend gathering this evidence before an access assessment or application. Then consider an OT letter explaining the impairment's impact on daily activities, participation and support needs. The NDIA makes the access decision.