Dr Wendy Bridges
Provider No. 235591LW
Ph 4950 9733 Fax 4952 9703
1st Floor / 56 Orchardtown Road
New Lambton 2305

RF

Patient's name | Medical practitioner's initials

Filling in this form

You can complete this form on your computer, print and sign it.

If you have a printed form:

- Use black or blue pen.
- Print in BLOCK LETTERS.
- Where you see a box like this ☐ ***Go to 1*** skip to the question number shown.

Patient's details (person who received the vaccine)

1 Medicare card number

2594 13981 6 Ref no. 1

or

Individual Healthcare Identifier

8 0 0 3 6 0

2 Mr ☐ Mrs ☐ Miss ☐ Ms ☒ Other ☐

Family name

FRANCIS

First given name

REBECCA

Second given name

LEIGH

3 Date of birth (DD MM YYYY)

06 01 1986

4 Postal address

34 Dudley Rd
Charlestown
Postcode 2290

5 Has the patient been known by any other names?

No ☒

Yes ☒ Give details below

REBECCA LEIGH
CAMPBELL

6 When did you first start treating the patient (DD MM YYYY)

08 06 2023 pt of this practice

7 Provide details of the treatment provided since 13/5/10

routine medical check ups and
screens
blood tests, other tests
related pericarditis
referrals related to scan
prescriptions related to scan
mental support

Medical opinion of diagnosis and link to vaccination

For the purposes of the Scheme a claimant may be diagnosed with a claimable medical condition (Question 8) and/or diagnosed with an injury that was sustained during the administration of a COVID-19 vaccination (Question 9). For more information refer to the Guidance for Conditions Document and Guidance for Injuries Document on the Department of Health website.

8 The patient has been diagnosed with the following claimable medical condition(s) by a medical specialist in the **relevant field of practice**, as outlined in the Guidance for Conditions Document on the Department of Health website.

In the case of a fatal outcome, a forensic pathologist may be considered a relevant specialty for the clinical conditions covered by the Scheme.

Tick all that apply

Eligible Clinical Condition / Applicable COVID-19 Vaccine(s) / Diagnosed by:	
Anaphylactic Reaction Astra Zeneca/Pfizer/Moderna/Novavax All medical practitioners	☐
Thrombosis with Thrombocytopenia Syndrome AstraZeneca Haematologist	☐
Myocarditis Pfizer/Novavax/Moderna Cardiologist	☒
Pericarditis Pfizer/Novavax/Moderna Cardiologist	☒
Capillary Leak Syndrome AstraZeneca Intensive Care Medicine or Haematologist	☐
Guillain Barre Syndrome AstraZeneca Neurologist or Immunologist	☐
Thrombocytopenia / Immune Thrombocytopenia AstraZeneca Haematologist or Immunologist	☐
Transverse Myelitus AstraZeneca Neurologist or Immunologist	☐
Cerebral Venous Sinus Thrombosis (CVST) without Thrombocytopenia AstraZeneca Haematologist or Neurologist	☐
Erythema Multiforme (Major) Pfizer/Moderna Dermatologist or Immunologist	☐

MCAOMO063 230411

W.B. R.F

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9 Read this before answering the following question.

The injury sustained during the administration of a COVID-19 vaccination can **not** be:

- contracting COVID-19
- psychological and psychiatric conditions
- secondary injuries (such as injury when fainting, or a haematoma at the injection site that becomes infected)
- headache
- fatigue
- injection site reaction
- muscle or joint pain
- dizziness
- diarrhoea
- pain in extremity
- fever
- insomnia
- nausea
- vomiting
- lethargy
- hyperhidrosis
- chills
- decreased appetite
- malaise
- lymphadenopathy
- somnolence
- abdominal pain
- pruritis
- urticaria/rash
- influenza like illness
- angioedema, or
- anxiety related reactions such as hyperventilation and fainting.

Has the patient been diagnosed with:

- an injury sustained during the physical act of administering a COVID-19 vaccination, or
- other moderate to significant physical injury giving rise to permanent impairment or the need for extended medical treatment?

No ☐

Yes ☒ What is the injury?

pericarditis
myo - pericardit >
severe POTS

severe psoriasis
psoriatic arthritis

all due to COVID
vaccine.

10 Date of symptoms onset (if known) (DD MM YYYY)

10 09 2021

11 Date of diagnosis (DD MM YYYY)

10 12 2021

12 Is your opinion based on another treating practitioner's assessment?

No ☐ *Go to 14*

Yes ☒

13 Name of treating practitioner

Dr Patrick Diu / Dr George Tolwinski

Treating practitioner's specialty or field

cardiology

Medicare provider number

2276375E / 4254 194T

Business phone number (including area code)

02 4943 9964 02 8488 8900

Email (if known)

info@nswcardiacservices.com.au

14 Explain how the diagnosis was reached. Refer to the 'Important information for patients and medical practitioners'.

a) Symptoms related to the claimable condition and/or injury

chest pain, grabbing, pleuritic
fatigue
poor exercise tolerance
syncope / pre syncope
palpitations

b) Examination finding and how these demonstrate the diagnosis of the claimable condition/injury

bedside U/S performed at
JSHT (John Hunter Hospital)
19/9/21 demonstrated
pericardial effusion
D/e study MRI Dr Tuuna/DIU
10/6/22 demonstrated previous myocarditis

c) Investigations conducted as part of the diagnosis or assessment of the claimable condition

ECG
multiple haematological serological
investigations
cardiac MRI with dye
cardiac echo repeated
holter monitor, repeated
chest x ray
CT with contrast

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d) Results from investigations and how the interpretation of these results led to the diagnosis of the claimable condition

Fluid around heart on ultrasound
= pericardial effusion + clinical picture = pericarditis
ongoing poor cardiac func
+ MRI findings of muscle inflammation = myocarditis

The claims assessment considers whether information has been submitted to explain the diagnosis. The assessment does not re-diagnose the patient.

If you are not the treating practitioner, provide a copy of the treating practitioner report.

15 In your medical opinion was the diagnosed medical condition and/or injury most likely caused by the COVID-19 vaccine received by the patient and less likely caused by any other circumstance?

No ☐
Yes ☒ Explain why the most likely cause of the diagnosed medical condition and/or injury is the COVID-19 vaccination. This may include use of recognised causality assessment guidelines.

nil prior cardiac hstry
nil risk factors
temporally connected - started within days of vaccine.
known and validated complication of vaccine.

Explain how other potential causes of the diagnosed medical condition and/or injury have been considered, and appear less likely to have contributed to the claimant's diagnosis than the vaccination received by the claimant. This statement must include a summary of results from examination findings or investigations that led to the conclusion that other causes are less likely than the vaccination received by the claimant.

multiple bloods shd
are negative for ischaemic, autoimmune and inflamatory pathologies.
Echo + MRI showed pericarditis + myocarditis
But NO other pathologies
2x cardiologists' review
dismissed other causes

Details of loss suffered by patient

16 Did the patient die as a result of the Harm?

No ☒ *Go to 19*
Yes ☐ Provide a copy of the death certificate.

17 In your medical opinion advise the circumstances of the patient's death

18 In your medical opinion did the Harm suffered by the patient cause, or materially contribute to their death?

No ☐ *Go to 54*
Yes ☐ Provide comments with regards to the cause(s) of death specified in the death certificate or medical cause of death certificate.

Go to 54

19 Was the patient admitted to hospital as an inpatient for treatment of the Harm suffered?

No ☐ *Go to 21*
Yes ☑

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20 If the patient was admitted to hospital as an inpatient:

Provide documentation verifying the admission of the patient to hospital as an inpatient where treatment for the Harm was sought and received.

OR

If not covered in the hospital document, give the following details:

Date of admission (DD MM YYYY) see attachments multiple admission

Date discharged (DD MM YYYY)

Name of hospital

Address

Postcode

Reason for admission as an inpatient to hospital

Go to 24

21 Read this before answering the following question.

Waiver to the Hospitalisation Requirement

Questions 21–23 are required to be answered to support why the patient was not admitted to hospital as an inpatient.

Why was the patient not admitted to hospital as an inpatient?

- ☐ Due to the nature of the Harm suffered
- ☐ The patient was in a rural or remote area at the time the Harm was suffered, making it difficult for them to access a Hospital.

  Provide evidence to support the location of where the patient was when they suffered the Harm.
- ☐ Patient died

  Date of death (DD MM YYYY)

  Provide death certificate.

Go to 53

- ☐ None of the above

  STOP This claim is not eligible under the COVID-19 Vaccine Claims Scheme. For more information on eligibility, go to **servicesaustralia.gov.au/covid19vaccineclaims**

22 Did the patient receive treatment mostly likely related to the Harm in an outpatient care setting under the supervision of a Treating Specialist or Consultant Physician?

No ☐ Go to 24

Yes ☐

23 Outpatient care

Outpatient care means any treatment that is provided by or under the supervision of a Treating Specialist or Consultant Physician in an outpatient care setting, outside of Hospital admission, but which does not include Emergency Department Presentation.

Outpatient care may be provided in a hospital outpatient clinic, private clinic or primary care centre.

Give details of the nature and duration of the outpatient care

Name of the Treating Specialist or Consultant Physician who provided this care

Business phone number (including area code)

Email

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24 Based on your medical opinion what are the circumstances, nature and severity of the Harm suffered by the patient?

The patient has received severe, ongoing, persistent life altering diagnosis with daily lung/chest symptoms that is extremely distressing according to known complications of condition

25 What is your current view of the prognosis for the patient?

uncertain - world wide medical studies continue there are many people affected long term. Likely to be severe and lifelong, ongoing poor prognosis.

26 What period did the patient suffer the Harm? Give dates or, if the patient is still experiencing the symptoms write 'ongoing' and give an indication of the estimated duration

copooly.

ongoing, lifelong

27 Is the patient claiming for past and/or future lost earnings as a result of the Harm?

No ☐ *Go to 33*
Yes ☒

28 Has the patient required time off work or caring duties as a result of the Harm?

No ☐ *Go to 33*
Yes ☒

29 List the period of time the patient was unable to work due to the Harm

From (DD MM YYYY) 13 09 2021

To* (DD MM YYYY)

* If the patient **has not** been able to return to work due to the Harm, write the expected return to work date below. If unknown, estimate how long the symptoms will affect the patient's capacity to work. **To be able to assess this claim, this needs to be completed.**

Expected return to work date (DD MM YYYY)

If unknown, estimate how long the symptoms will affect the patient's capacity to work

Less than 3 months ☐ 13–24 months ☐
3–12 months ☐ More than 24 months ☒

Explain how this date or estimate was determined and if the patient will return to work on a reduced basis

patient has been by myself, her cardiologist, and specialist could advise, and general physician. All agree with ongoing issues and severe and ongoing symptoms incapacitated for work

30 Explain why the patient was unable to work during this period

dyspnoea
fatigue
syncope
presyncope
palpitations

31 Has the patient returned to work on a reduced basis?

No ☐
Yes ☒ Give details

unable to work 27/12/21 - 31/10/22
again unable to work 2/5/22 - 1/8/22.
worked 1 day/week for next 3 weeks
ceased work on 23/9/22
unable to work since.

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32 Outline the past and future impacts and/or restrictions on the patients ability to work, including whether they will be unable to work or only able to work on a reduced basis.

note previous answer
unable to work since Sept 2021
unable to work for foreseeable future.

33 Is the patient claiming Gratuitous Attendant Care Services under the Scheme?

No ☐ *Go to 37*
Yes ☑

34 Provide the nature and duration of the services

initially required medication administration / now Webster Pack
transportation assistance
companionship + emotional support
health maintenance
co-ordination of care

35 Based on your medical opinion, to what extent were/are the services reasonably required as a result of the Harm?

Tick all that apply

There is (or was) a reasonable need for the services to be provided ☒
The need has arisen (or arose) most likely because of the Harm suffered ☒
The services were (or will be) provided to the patient mostly like as a result of the Harm suffered ☒

36 Was/is the Gratuitous Attendant Care Services required for:

- 6 or more hours a week, and
- for a period of at least 6 consecutive months?

No ☐
Yes ☒

37 Is the patient claiming Paid Attendant Care Services?

No ☐ *Go to 40*
Yes ☒

38 Provide the nature and duration of the services provided/ required

cleaning paid 15/11/21 to 13/12/22
now ceases 14/10/24 → ongoing
cleaning house 18/12/2022
- 29/24/24. Household maintenance tasks (housework) 07/09/23
ongoing.

39 Based on your medical opinion, to what extent were/are the services reasonably required as a result of the Harm?

Tick all that apply

There is (or was) a reasonable need for the services to be provided ☑
The need has arisen (or arose) most likely because of the Harm suffered ☑
The services were (or will be) provided to the patient mostly like as a result of the Harm suffered ☒

40 Is the patient claiming Gratuitous Domestic Services?

No ☐ *Go to 43*
Yes ☑

41 Based on your medical opinion, advise:

- whether the COVID-19 vaccine recipient is unable to or has a reduced capacity to provide the Gratuitous Domestic Services they provided prior to suffering the Harm
- the extent to which the COVID-19 vaccine recipient's capacity to provide the Gratuitous Domestic Services they provided prior to suffering the Harm has reduced
- the likely duration of the COVID-19 vaccine recipient's reduced capacity to provide the Gratuitous Domestic Services they provided prior to suffering the Harm, and
- that there is a reasonable expectation that the COVID-19 vaccine recipient would most likely have provided the services to the care recipient(s) for at least 6 hours per week and for a period of at least 6 consecutive months.

severe and ongoing loss of function of gratuitous domestic services.
Before COVID vaccine patient
- ran household - carer husband son
- ran husbands business - carer father
operated high level.

After COVID vaccine.
- cannot manage own self care let alone others
- 1 domestic task per day.

42 Based on your medical opinion, to what extent were/are the services reasonably required as a result of the Harm?

Tick all that apply

There is (or was) a reasonable need for the services to be provided ☑
The need has arisen (or arose) most likely because of the Harm suffered ☑
The services were (or will be) provided to the patient mostly like as a result of the Harm suffered ☒

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W.S.
R.F.

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53 Is there any other information or supporting documents you consider relevant for us to assess the claim?
This could include medical reports or opinions from other practitioners.

No ☐
Yes ☒ Give details

functional fitness report
psychology report
total disability pay out letter
occupational therapy report
TPD confirmation letter

Provide a copy of any documents.

Additional claims for previously compensated cases

54 Has a claim under the Scheme been lodged for the patient already?

No ☒ *Go to 57*
Yes ☐

55 **Further related Harm**
Has the Harm suffered by the patient gotten significantly worse and requires additional treatment for a period of at least 6 months after the latest date for which Compensation was originally paid under the Scheme in respect of treatment?

No ☐
Yes ☐ Outline how the Harm has gotten significantly worse, what treatment is required and the period it is required for

56 **Unrelated Harm**
Is the Harm for a different and Unrelated Harm to the previous Harm that was not known or foreseeable when the first claim was lodged?

No ☐
Yes ☐ Give details of the Harm

Reporting practitioner's details

57 Dr ☒ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name
Bridges

First given name
Wendy

58 Practice address
Lvl 1, 58 Orchardtown Rd
New Lambton NSW
Postcode 2305

59 Medicare provider number
2358591LW

60 Qualification (including field of specialty)
B Med, FRACGP

61 Business phone number (including area code)
4950 9733

Email
wendy.b@blacksultdoctors.com.au

Privacy notice

62 **Important information for the doctor or medical specialist**
Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by Medicare for the assessment and administration of payments and services. Your information may be used by us or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law. You can get more information about the way in which we will manage your personal information, including our privacy policy, to **servicesaustralia.gov.au/privacy** or by requesting a copy from the agency.

W. B.

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43 Is the patient claiming past out of pocket costs?

No ☐ *Go to 45*

Yes ☒

44 For these costs provide:

- evidence as to the nature of the treatment received by the patient for which a claim for past out of pocket expenses is made and, if available, the names, contact details, provider numbers, and specialities or field of specialities (if any) of the practitioners that provided such treatment, and
- in your medical opinion as to whether, why and the extent to which the treatment was reasonably required as a result of the Harm suffered.

all required as result of harm suffered.

please see post out of pocket spreadsheet for evidence. - supplements
- cardiac insurance
- naturopath
- private cardiologist / general physician
- private G.P.
- private psychologist
- private remedial massage/chiro practic
- private acupuncturist
- private breathing specialist
- medications
- private imaging/investigations
- hospital fees
- private exercise physiology

45 Is the patient claiming for future out of pocket costs?

No ☐ *Go to 47*

Yes ☒

46 For these costs, provide:

- evidence as to the nature and estimated duration (for example, quotes) of any future treatment that is reasonably required by the patient as a result of the Harm likely caused by the COVID-19 vaccine, and
- your medical opinion as to whether, why and the extent to which the treatment is reasonably required as a result of the Harm suffered.

as above, ongoing

47 Is the patient claiming for pain and suffering?

No ☐ *Go to 53*

Yes ☒

48 In your medical opinion do you believe the patient suffered from pain and suffering?

No ☐

Yes ☒

49 Outline the nature of the pain and suffering (impact on family)

physical pain
emotional pain and suffering
loss of social and family roles and opportunities
fear and uncertainty with emerging diagnosis

50 Nature of the impairment to the patient's ability to lead a normal life including the impact on their pre-existing earning capacity

severe - see question 41
long term physical + emotional suffering has removed her normal life completely and her hope for normal life in future.

51 The likely duration of the Harm, pain and suffering and impairment

lifelong

52 Is there any other relevant information that needs to be considered in determining the patient's pain and suffering?

No ☒

Yes ☐ Give details

Provide a copy of any documents.

W.B.
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Dr Wendy Phillips
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Patient's name | Medical practitioner's initials

Declaration

63 **I declare that:**

- the patient has given consent that I can disclose medical information about them for the purpose of determining the patient's eligibility under the Scheme
- I have received reports, case notes from the treating practitioner and am qualified (by reference of my professional qualifications and expertise) to complete this report on the patient's condition as a result of the Harm suffered and the treatment the patient has required, or
- I am the treating practitioner who has treated or examined the patient in relation to the Harm suffered. I am qualified (by reference of my professional qualifications and expertise) to provide:
  - the treatment given to the patient, and
  - the opinions contained in any report (including this report) provided about the patient.
- the information I have provided in this form is complete and correct.

I understand that:

- Services Australia, the Department of Health (including the Therapeutic Goods Administration) and their contractors (which includes members of the Independent Expert Panel, as well as other medical and legal professionals) may contact me to confirm and discuss this report and the supporting information provided.
- giving false or misleading information is a serious offence.

Reporting practitioner's signature

Date (DD MM YYYY)

18 | 09 | 2021

Checklist

64 Documents the patient will need to supply that the doctor might have.

	Tick all that apply
A copy of the treating practitioner report (**Question 14**)	☑
A copy of the death certificate (**Question 16**)	☐
Evidence of inpatient hospitalisation and cause of inpatient hospitalisation (**Question 20**)	☑
Any other evidence and/or report you believe will assist in the assessment of determining eligibility of the claim (**Questions 52 and 53**)	☑

Returning this form

Give the completed form and any supporting evidence to your patient, who can provide it to us when they submit their claim under the COVID-19 Vaccine Claims Scheme.