Te Tira Ahu Ika A Whiro
VETERANS' AFFAIRS
New Zealand

Viet Nam Veterans Annual Medical Assessment (AMA)

Background

In recognition of the fact that Viet Nam veterans were exposed to a toxic environment during their service in Viet Nam, the government is funding an ongoing medical assessment for all Viet Nam veterans.

Viet Nam veterans have faced challenges that most New Zealanders would have difficulty comprehending. Veterans have faced the risk of injury or death in armed conflict, exposure to natural and man made hazards in a range of different environments and dealt with the effects of being in high intensity, stressful and dangerous situations for extended periods of time. As a result of their service experiences, veterans are susceptible to a range of health and wellbeing issues.

In addition to the stress of combat, Viet Nam veterans found that they were a target for anti war sentiment during New Zealand's participation in the Viet Nam war. This has compounded the impact of many veterans' experience. For many veterans, the lack of recognition of the role they played in Viet Nam and the failure of governments in the past to recognise that veterans were exposed to a toxic environment during their service prevented them from coming to terms with their experience.

Purpose of the Assessment

The main purpose of this medical assessment ("AMA") is to assess the general health and well-being of individual Viet Nam veterans. The medical assessment is also to ensure detection of recognised long term health effects of exposure to the toxic environment that existed in Viet Nam. Veterans' Affairs ("VA") will meet the cost of the medical assessment.

Information for the veteran

Please complete Part 1 of this form and arrange an appointment with your medical practitioner. If you have a VA medical treatment card please take this to your appointment and ensure your medical practitioner is aware of your current accepted disabilities as listed on your card.

What we would like you to do

Your medical practitioner will complete Part 2 of the form.

Please note that if you are currently on a War Disablement Pension and if as a result of your AMA you wish to apply for new conditions and/or reassessment of accepted disabilities, you will be transferred to a Disablement Pension and your application will be determined using a new decision-making process under the Veterans' Support Act 2014.

If you wish to apply for new conditions please complete Part 3.

If you wish to reassess accepted disabilities please complete Part 4.

Before returning the AMA form please verify that you have:

- read and understand the Privacy Statement on page 9
- completed the Signature Block on page 9
- completed the checklist on page 10.

Information for the Medical Practitioner

Please complete Part 2 (pages 4, 5 and 6) of this form. If the veteran has been diagnosed with any of the specified conditions listed in Part 2 and the diagnosis of the condition has not previously been provided to VA, please provide a detailed summary of the medical information and attach copies of any reports you hold confirming the diagnosis.

Whenever possible we undertake to support prevention of any of the presumed conditions listed in this AMA. If you notice any pre cursors, warning signs or symptoms of any of the presumed conditions listed in this AMA and treatment or investigation is required that will help prevent or delay the onset of the condition, please make note of these in Q17 of this form so that we can consider any funding costs that may be incurred. A Case Manager will discuss any investigation or treatment identified directly with the veteran regarding approval of funding.

VA will meet the cost of the medical assessment upon receipt of the **completed** form and your invoice.

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Offences
(section 270, Veterans' Support Act 2014)

It is an offence to make a false statement or provide misleading information and anyone who does so commits an offence against this section and is liable on conviction to a term of imprisonment not exceeding 3 months or a fine not exceeding $5,000.

Assistance

If you have any questions or require assistance completing this form, you can contact us using the details shown below:

Freephone 0800 483 8372 / 0800 4 VETERANS (or +64 4 495 2070 if calling from overseas)

You can email: **veterans@nzdf.mil.nz** or visit our website: **www.veteransaffairs.mil.nz**

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Part 1 - Veteran to complete

Personal Details

1 **Work and Income / Client Number** **(if known)**

2 **Title** (tick) ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other

3 **Surname**

4 **Given Name/s**

5 **Other Known Name/s**

6 **Date of Birth** / /

7 **Residential Address**

Country (if not New Zealand) Post Code

8 **Postal Address** (if different from residential address)

Country (if not New Zealand) Post Code

9 **Other Contact Details**

Home Phone	Work Phone
Mobile Number	Fax Number
E-mail Address	

10 **Relationship Status** ☐ Married ☐ De facto ☐ Widowed ☐ Divorced ☐ Single

If you are in a relationship please complete your partner's details below

Name
Address
Contact Details

Part 2 - Medical Practitioner to complete

Medical Assessment

11 **Veteran's NHI Number**

12 **Examination Date** **Prior to today when did you last examine the veteran?** / /

13 **Terminal Condition**

Does the veteran suffer from an advanced progressive disease likely to cause death within 12 months?

No Yes If yes, please state the condition below

14 **Enrolment History** **Is the veteran enrolled with your practice?** No Yes

If yes, how long have they been enrolled with you? Years Months

If no, provide the name and contact details of their usual medical practitioner (if known)

Name of Practitioner
Practice Name

15 **Medical Practitioner Identity**

HPI No. **Medical Council Registration No.**

Name
Practice Stamp (or address and telephone)
Medical Practitioner Signature / /

Please attach your invoice to this form along with any supporting documentation such as copies of medical reports, blood test results etc.

Veterans' Affairs will meet the cost of the consultation and completion of this medical assessment form upon receipt of the completed form and your invoice.

Presumptive service-related conditions

The Institute of Medicine of the US National Academy of Sciences (IOM) has identified that exposure to dioxin or to herbicides used in Viet Nam can lead to long term health effects.

Please indicate (✓) if the veteran has previously or currently suffers from any of the following conditions:

- ☐ Chronic Lymphocytic Leukaemia (including hairy-cell leukaemia and other chronic B-Cell leukaemia's)
- ☐ Soft Tissue Sarcoma
- ☐ Non-Hodgkin's Lymphoma
- ☐ Hodgkin's Disease
- ☐ Chloracne
- ☐ Porphyria Catania Tarda
- ☐ Multiple Myeloma
- ☐ Respiratory Cancers (Lung, Bronchus, Larynx, Trachea)
- ☐ Prostate Cancer
- ☐ Acute and Sub acute Peripheral Neuropathy
- ☐ Type 2 Diabetes
- ☐ Hypertension
- ☐ AL-Type primary Amyloidosis
- ☐ Parkinson's Disease
- ☐ Ischaemic Heart Disease
- ☐ Stroke

If the veteran has been diagnosed with any of the presumptive conditions outlined above which have NOT previously been reported to Veterans' Affairs, provide a summary of each <u>new</u> condition below and attach copies of the medical evidence:

1/ Medical diagnosis
Basis for diagnosis
Current treatment and impact on daily living
Date first diagnosed — Still under investigation Yes ☐ No ☐
2/ Medical diagnosis
Basis for diagnosis
Current treatment and impact on daily living
Date first diagnosed — Still under investigation Yes ☐ No ☐

Please provide a brief summary of any other new conditions

1/ Medical diagnosis

Basis for diagnosis

Current treatment and impact on daily living

Date first diagnosed | Still under investigation Yes ☐ No ☐

2/ Medical diagnosis

Basis for diagnosis

Current treatment and impact on daily living

Date first diagnosed | Still under investigation Yes ☐ No ☐

Medical Assessment Summary

Please comment on the veteran's medical history, general state of health and any changes to accepted disabilities (as listed on the veteran's medical treatment card). If additional investigation is required for diagnosed condition/s, please provide details and your recommendation of who this is undertaken by:

Part 3 - Veteran to complete

Application for Disablement Pension (if applicable)

If you wish to apply for a Disablement Pension for any of the medical conditions identified by your medical practitioner in Part 2, that you believe have been caused, contributed to or aggravated by qualifying service, please complete the details below:

1 **Condition:**
Symptoms:
State the period of service where the injury / illness occurred:
How do you believe your service has caused, contributed to or aggravated this condition? Continue on further page if needed
Date you first became aware of condition:
Have you applied to another agency such as ACC, NZDF Accredited Employment Programme (AEP) or other insurer for this condition? (If applicable please name relevant agency)

2 **Condition:**
Symptoms:
State the period of service where the injury / illness occurred:
How do you believe your service has caused, contributed to or aggravated this condition? Continue on further page if needed
Date you first became aware of condition:
Have you applied to another agency such as ACC, NZDF Accredited Employment Programme (AEP) or other insurer for this condition? (If applicable please name relevant agency)

For additional conditions please copy and complete this sheet

Part 4 - Veteran to complete

Accepted disabilities you would like reassessed (if applicable)

If your accepted disabilities (as listed on your medical treatment card) have changed, as commented by your medical practitioner in Part 2 and you wish to apply for reassessment, please complete the details below:

1	**Disability:**
How do you believe your accepted disability has become worse since it was last assessed by Veterans' Affairs and in what way?	

2	**Disability:**
How do you believe your accepted disability has become worse since it was last assessed by Veterans' Affairs and in what way?	

3	**Disability:**
How do you believe your accepted disability has become worse since it was last assessed by Veterans' Affairs and in what way?	

For additional conditions please copy and complete this sheet

Privacy Statement

You can read our full privacy statement on our website

Your personal information is managed in accordance with the privacy statement on our website:

- www.va.mil.nz/privacy

If you would like a copy of this posted to you please contact us:

- 0800 483 8372 from New Zealand
- +64 4 495 2070 outside New Zealand

Signature

This form must be signed either by the claimant or a person with the authority to act on the behalf of the claimant if they are unable to do so.

If the claimant didn't sign the form, **include one** of the following forms of evidence:

- Power of Attorney or Enduring power of Attorney (in relation to Property)
- Certificate of Administration (from the Public Trustee)

I acknowledge that:

- the information I have given in this claim form is true and correct
- Veterans' Affairs may obtain further information to assess and decide on my claim
- I have read and understood the Privacy Statement for Forms on www.va.mil.nz/privacy
- I authorize the collection and disclosure of health, clinical, or other personal information by or to Veterans' Affairs, held by any doctor or health practitioner or named agencies, or service provid-ers, or contractors for the purposes set out in the privacy statement; for the purposes of assess-ment of this claim; administration of any resulting entitlement; and the provision of any services, treatment or rehabilitation under the Veteran's Support Act 2014.

Signature | Please sign

Claimant or authorised person

Claimant or authorised person name

Claimant or authorised person signature

D D / M M / Y Y Y Y

Helper | Complete this section if you've helped the claimant to complete this form.

Helper name

Helper's relationship to claimant

Checklist

☑ **Please complete the checklist below to ensure your form is complete:**

☐ I have complete Part 1 of the form; and Parts 3 and 4 if applicable.

☐ I have attached any supporting information or documentation.

☐ My Medical Practitioner has completed Part 2 (pages 3, 4 and 5); attached their invoice and any supporting documentation.

☐ I have read the Privacy Statement on page 9.

☐ I have completed the Signature Block on page 9.

Send your completed form to:

Veterans' Affairs
PO Box 5146
Lambton Quay
WELLINGTON 6145