



New Zealand

**VETERANS'  
AFFAIRS**

Te Tira Ahu Ika A Whiro

# 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 8 and completed the Signature Block and Checklist on page 9.**

## 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.

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## **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](mailto:veterans@nzdf.mil.nz) or visit our website: [www.veteransaffairs.mil.nz](http://www.veteransaffairs.mil.nz)



## 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 new 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:

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

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

For additional conditions please copy and complete this sheet

## Part 4 - Veteran to complete

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### 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:

|  |
|--|
| <b>1</b> Disability:   |
|  |
| <b>How do you believe your accepted disability has become worse since it was last assessed by Veterans' Affairs and in what way?</b> |
|  |
|  |
|  |
|  |
|  |

|  |
|--|
| <b>2</b> Disability:   |
|  |
| <b>How do you believe your accepted disability has become worse since it was last assessed by Veterans' Affairs and in what way?</b> |
|  |
|  |
|  |
|  |
|  |

|  |
|--|
| <b>3</b> Disability:   |
|  |
| <b>How do you believe your accepted disability has become worse since it was last assessed by Veterans' Affairs and in what way?</b> |
|  |
|  |
|  |
|  |
|  |

**For additional conditions please copy and complete this sheet**



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## Privacy Statement

The Veterans' Support Act 2014 (the Act) which is administered by the New Zealand Defence Force allows us to obtain further information about you to help us assess your application. This may happen when you apply for or are receiving an entitlement. The Privacy Act 1993 requires us to tell you why we collect the information and what we will do with it.

You are not required to give Veterans' Affairs any information, but if you do not provide all the information we ask for, your application for an entitlement and/or assistance may not be able to be processed and may be returned to you.

### Why we collect information

The information we collect about you will be held by Veterans' Affairs New Zealand (Veterans' Affairs), which is a unit of the New Zealand Defence Force. We use this information for the purpose of:

- Administering claims and entitlements under the Veterans' Support Act 2014
- Enabling a comprehensive claims database to be maintained
- To monitor and evaluate the nature, incidence, severity and consequences of service-related illness and injuries
- The provision of appropriate treatment, rehabilitation and compensation
- Facilitating the monitoring of the operation of the Act and policy development
- The information you give us may be shared with other government agencies for several purposes, such as the Ministry of Social Development – consistency with other benefits, Accident Compensation Commission – consistency with other claims, Maritime New Zealand – for merchant navy records, Inland Revenue – for payment of tax on taxable entitlements, Archives New Zealand – for service records and the Department of Internal Affairs – to verify your date of birth.

We only collect information needed to manage the entitlements we administer.

### Using and sharing personal and health-related information

Veterans' Affairs may exchange information about you with your health practitioner(s) in order to provide you with the correct entitlements and assistance, to clarify any health-related information you give us and for the purposes of putting in place treatment and rehabilitation if required.

Veterans' Affairs will also collect personal and health information from a variety of sources including information provided when making an application to Veterans' Affairs, information supplied by others including treatment providers, and other government agencies.

The information we collect about you can be via various channels, such as email, telephone, face to face and in various formats, such as letters, forms and electronic file notes.

Veterans' Affairs uses personal information provided only for the purposes consistent with the reason it was obtained and will not share it with other parties unless there is a legal authority to do so.

### You have the right to access and correct your personal information

You may access personal information that we hold about you. You can ask us to correct errors contained in the information we have about you.

You can contact us at anytime if you have concerns on what information about you we are collecting and how it is or may be used.

**Please complete the Signature Block and Checklist on page 9**



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## Signature Block

### Applicant's signature block

- By ticking the boxes and signing this form:
- I confirm that the information provided in this form is, to the best of my knowledge, true and complete.
- I acknowledge that as part of processing this application, Veterans' Affairs may obtain further information in addition to what I have provided.
- I consent to the release and collection of health, clinical or other information to Veterans' Affairs held by any health practitioner, hospital, clinic, insurance company, Accident Compensation Commission, Ministry of Social Development, Department of Internal Affairs or other persons or agencies for the purposes of assessing and processing this application and administering any resulting entitlement or assistance.
- I am aware there are penalties for providing false information as set out in the information sheet at the front of this application.
- I have read and understand the Privacy Statement contained in this form.

**Veteran or Power of Attorney's name (print)**

**Signature**

**Date**

If you had assistance completing this form, print the persons name (and organisation they represent if applicable) below:

**If the veteran is unable to sign, due to physical or mental incapacity, the Signature Page must be completed by a person with authority to act on behalf of the veteran. If this situation applies you must also attach a certified copy of at least one of the following documents:**

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

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## 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 8 and completed the Signature Block on page 9.

### Send your completed form to:

Veterans' Affairs  
PO Box 5146  
Lambton Quay  
WELLINGTON 6145