Reference Determination Content

Example document — fictitious patient. A suggested draft determination prepared by the Veterans Health Centre from the matching example Diagnostic Assessment, to show how a DVA delegate could determine the claim. Names, dates, service details and clinicians are invented. It is not a decision of the Department of Veterans' Affairs.

Bruxism

Evidence

The evidence that I have considered in making this decision includes:

- Formal Claim with supporting statements;
- A Statement of your Service from the Department of Defence;
- Copies of your Service Medical Records.
- A Diagnostic Assessment by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 18 June 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 18 June 2025;
- A psychiatric assessment by the consultant psychiatrist, dated 14 November 2009;
- A psychiatric review by the consultant psychiatrist, dated 3 June 2010;
- A pre-deployment dental examination by the dental officer, dated 18 January 2011;
- A deployed health record by the medical officer, Role 1 medical post, Afghanistan, dated 20 April 2011;
- A trauma admission by the CT brain and operation report, Role 3 hospital, Afghanistan, dated 10 July 2011;
- A rehabilitation medicine consultation by the rehabilitation physician, dated 26 July 2011;
- Nursing notes and dental consultation by the dental officer, dated 4 August 2011;
- An audio-video polysomnography report by the sleep physician, dated 16 September 2011;
- A specialist consultation by the oral medicine specialist, dated 21 September 2011;
- A separation medical examination by the medical officer, Garrison health centre, dated 22 July 2019;
- A general practice consultation by the general practitioner, dated 14 September 2020;
- A dental consultation and radiographs by the dentist, dated 14 September 2020;
- A repeat polysomnography report by the sleep physician, dated 28 September 2020.

Your service

I have identified that you have the following service:
Australian Defence Force service between :

8 March 2004 and 17 October 2019

Bruxism

You have stated that your condition was caused by:

- *experiencing a moderate to severe traumatic brain injury within the 30 days before clinical onset or clinical worsening*
- *having a clinically significant neurological condition as specified at the time of the clinical onset or clinical worsening*
- *having an anxiety disorder at the time of clinical onset or clinical worsening*
- *taking any of the following at the time of the clinical onset or clinical worsening: amphetamines or amphetamine derivatives, including methamphetamine, 3,4-methylenedioxymethamphetamine (ecstasy or MDMA)*
- *taking any of the following at the time of the clinical onset or clinical worsening: antipsychotics*
- *taking any of the following at the time of the clinical onset or clinical worsening: dexamphetamine*
- *taking any of the following at the time of the clinical onset or clinical worsening: methylphenidate*
- *taking any of the following at the time of the clinical onset or clinical worsening: selective serotonin reuptake inhibitors*
- *taking any of the following at the time of the clinical onset or clinical worsening: serotonin and noradrenaline (norepinephrine) reuptake inhibitors*
- *having gastro-oesophageal reflux disease at the time of the clinical onset or clinical worsening*

Diagnosis: Bruxism

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 18 June 2025, and is supported by a specialist consultation by the oral medicine specialist, dated 21 September 2011.

I am satisfied this is the appropriate diagnosis.
In determining your claim for this condition, I have applied the SOP:

Statement of Principles concerning Bruxism (Balance of Probabilities) (No. 8 of 2026)

which sets out the factors that can connect the condition with service.

I am satisfied that you have met the following factor:

- *experiencing a moderate to severe traumatic brain injury within the 30 days before clinical onset or clinical worsening*

- *having a clinically significant neurological condition as specified at the time of the clinical onset or clinical worsening*
- *having an anxiety disorder at the time of clinical onset or clinical worsening*
- *taking any of the following at the time of the clinical onset or clinical worsening: amphetamines or amphetamine derivatives, including methamphetamine, 3,4-methylenedioxymethamphetamine (ecstasy or MDMA)*
- *taking any of the following at the time of the clinical onset or clinical worsening: antipsychotics*
- *taking any of the following at the time of the clinical onset or clinical worsening: dexamphetamine*
- *taking any of the following at the time of the clinical onset or clinical worsening: methylphenidate*
- *taking any of the following at the time of the clinical onset or clinical worsening: selective serotonin reuptake inhibitors*
- *taking any of the following at the time of the clinical onset or clinical worsening: serotonin and noradrenaline (norepinephrine) reuptake inhibitors*
- *having gastro-oesophageal reflux disease at the time of the clinical onset or clinical worsening*

I have noted your contention as to the cause of this condition. The available evidence indicates, I have noted your contention to the cause of your condition. Your service medical records indicate that you presented to the health facility with loud nightly tooth grinding witnessed by ward staff, daytime jaw clenching, morning jaw and temple pain, tender enlarged masseter muscles and fresh wear facets with a fractured molar cusp on 4 August 2011.

The diagnosis was confirmed by an oral medicine specialist on 21 September 2011 on the basis of witnessed grinding during sleep, awake clenching, fresh attrition facets on the canines and incisors, a fractured molar cusp, morning jaw pain and tender, hypertrophied masseter muscles. Audio-video polysomnography on 16 September 2011 recorded rhythmic masticatory muscle activity at 6.2 episodes per hour with grinding sounds, which meets the polysomnographic criteria for definite sleep bruxism. This meets the Statement of Principles definition of bruxism.

This has then led to further investigations and the diagnosis of your condition of *Bruxism*. I have accepted your condition of *Bruxism*.

Having considered your service records and the available medical evidence, I am satisfied the SOP is met and that this condition is related to your peacetime service.

I have therefore accepted that this condition is related to your service with effect from 2 August 2011.

Bruxism (Worsening)

Evidence

The evidence that I have considered in making this decision includes:

- Formal Claim with supporting statements;
- A Statement of your Service from the Department of Defence;
- Copies of your Service Medical Records.
- A Diagnostic Assessment by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 18 June 2025;
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- A rehabilitation medicine consultation by the rehabilitation physician, dated 26 July 2011;
- Nursing notes and dental consultation by the dental officer, dated 4 August 2011;
- An audio-video polysomnography report by the sleep physician, dated 16 September 2011;
- A specialist consultation by the oral medicine specialist, dated 21 September 2011;
- A separation medical examination by the medical officer, Garrison health centre, dated 22 July 2019;
- A general practice consultation by the general practitioner, dated 14 September 2020;
- A dental consultation and radiographs by the dentist, dated 14 September 2020;
- A repeat polysomnography report by the sleep physician, dated 28 September 2020.

Your service

I have identified that you have the following service:
Australian Defence Force service between :

8 March 2004 and 17 October 2019

Bruxism (Worsening)

You have stated that the worsening of your condition was caused by:

- *experiencing a moderate to severe traumatic brain injury within the 30 days before clinical onset or clinical worsening*
- *having a clinically significant neurological condition as specified at the time of the clinical onset or clinical worsening*
- *having an anxiety disorder at the time of clinical onset or clinical worsening*
- *taking any of the following at the time of the clinical onset or clinical worsening: amphetamines or amphetamine derivatives, including methamphetamine, 3,4-methylenedioxymethamphetamine (ecstasy or MDMA)*
- *taking any of the following at the time of the clinical onset or clinical worsening: antipsychotics*
- *taking any of the following at the time of the clinical onset or clinical worsening: dexamphetamine*
- *taking any of the following at the time of the clinical onset or clinical worsening: methylphenidate*
- *taking any of the following at the time of the clinical onset or clinical worsening: selective serotonin reuptake inhibitors*
- *taking any of the following at the time of the clinical onset or clinical worsening: serotonin and noradrenaline (norepinephrine) reuptake inhibitors*
- *having gastro-oesophageal reflux disease at the time of the clinical onset or clinical worsening*
- *inability to obtain appropriate clinical management for bruxism before clinical worsening*

Diagnosis: Bruxism (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 18 June 2025, and is supported by a specialist consultation by the oral medicine specialist, dated 21 September 2011.

I am satisfied this is the appropriate diagnosis.
In determining your claim for this condition, I have applied the SOP:

Statement of Principles concerning Bruxism (Balance of Probabilities) (No. 8 of 2026)

which sets out the factors that can connect the condition with service.

I am satisfied that you have met the following factor:

- *experiencing a moderate to severe traumatic brain injury within the 30 days before clinical onset or clinical worsening*
- *having a clinically significant neurological condition as specified at the time of the clinical onset or clinical worsening*
- *having an anxiety disorder at the time of clinical onset or clinical worsening*

- *taking any of the following at the time of the clinical onset or clinical worsening: amphetamines or amphetamine derivatives, including methamphetamine, 3,4-methylenedioxymethamphetamine (ecstasy or MDMA)*
- *taking any of the following at the time of the clinical onset or clinical worsening: antipsychotics*
- *taking any of the following at the time of the clinical onset or clinical worsening: dexamphetamine*
- *taking any of the following at the time of the clinical onset or clinical worsening: methylphenidate*
- *taking any of the following at the time of the clinical onset or clinical worsening: selective serotonin reuptake inhibitors*
- *taking any of the following at the time of the clinical onset or clinical worsening: serotonin and noradrenaline (norepinephrine) reuptake inhibitors*
- *having gastro-oesophageal reflux disease at the time of the clinical onset or clinical worsening*
- *inability to obtain appropriate clinical management for bruxism before clinical worsening*

I have noted your contention as to the cause of this condition. The available evidence indicates, I have noted your contention to the cause of your condition. Your service medical records indicate that you presented to the health facility with loud nightly tooth grinding witnessed by ward staff, daytime jaw clenching, morning jaw and temple pain, tender enlarged masseter muscles and fresh wear facets with a fractured molar cusp on 4 August 2011.

The diagnosis was confirmed by an oral medicine specialist on 21 September 2011 on the basis of witnessed grinding during sleep, awake clenching, fresh attrition facets on the canines and incisors, a fractured molar cusp, morning jaw pain and tender, hypertrophied masseter muscles. Audio-video polysomnography on 16 September 2011 recorded rhythmic masticatory muscle activity at 6.2 episodes per hour with grinding sounds, which meets the polysomnographic criteria for definite sleep bruxism. This meets the Statement of Principles definition of bruxism.

After the condition arose, it was worsened during your service. You sustained a moderate traumatic brain injury in an improvised explosive device blast on 10 July 2011, with loss of consciousness of about 45 minutes, a Glasgow Coma Scale score of 11 and post-traumatic amnesia of three days. CT of the brain on 10 July 2011 showed a left acute subdural haematoma with midline shift, evacuated by craniotomy, and the residual collection was still present on CT of 17 July 2011. A psychiatrist diagnosed generalised anxiety disorder on 14 November 2009, arising from your service, and it required ongoing treatment with sertraline and later desvenlafaxine and psychology. Dexamphetamine, an amphetamine, was prescribed at 10 mg twice daily from May 2017 for attention deficits after the service-related brain injury, and you were taking it at the worsening on 14 September 2020, as recorded at your separation medical and in the general practice record. Quetiapine, an antipsychotic, was prescribed at 50 mg at night from 3 June 2010 for nightmares of service-related posttraumatic stress disorder and was being taken at the onset on 2 August 2011, as recorded on the ward medication chart. Dexamphetamine

10 mg twice daily was prescribed from May 2017 for post-traumatic inattention following the service-related brain injury and was being taken at the worsening on 14 September 2020. Methylphenidate 10 mg twice daily was commenced on 26 July 2011 by the rehabilitation physician for post-traumatic inattention and was being taken at the onset on 2 August 2011, recorded on the ward medication chart. Sertraline, a selective serotonin reuptake inhibitor, was prescribed from 14 November 2009 at 150 mg daily for service-related posttraumatic stress disorder, depression and anxiety, and was being taken at the onset on 2 August 2011. Desvenlafaxine, a serotonin and noradrenaline reuptake inhibitor, replaced sertraline in March 2016 at 100 mg daily for the same service-related psychiatric conditions and was being taken at the worsening on 14 September 2020. Gastro-oesophageal reflux disease was diagnosed by a medical officer on 20 April 2011 and treated continuously with esomeprazole 40 mg daily. Your prescribed occlusal splint fractured in February 2020 and could not be replaced for seven months, from February to September 2020, because non-urgent dental services were suspended under the COVID-19 restrictions and your post-discharge dental entitlement was unresolved.

This has then led to further investigations and the diagnosis of your condition of *Bruxism (Worsening)*. I have accepted your condition of *Bruxism (Worsening)*.

Having considered your service records and the available medical evidence, I am satisfied the SOP is met and that the worsening of this condition is related to your peacetime service.

I have therefore accepted that the worsening of this condition is related to your service with effect from 2 August 2011.

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