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.

Chest - Anxiety - related Chest Pain

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 2 April 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 2 April 2025;
- An incident report and treatment record by Role 2 facility, Afghanistan, dated 14 July 2009;
- A psychiatric assessment by the consultant psychiatrist, dated 9 March 2011;
- A gastroscopy report by the gastroenterologist, dated 9 March 2011;
- A psychiatric review by the consultant psychiatrist, dated 21 August 2012;
- A physiotherapy breathing assessment by the physiotherapist, dated 21 August 2012;
- A treatment record and ECG by the medical officer, Middle East Area of Operations, dated 22 March 2013;
- A consultation (chest X-ray and stress echocardiogram reports) by the senior medical officer, dated 24 April 2013;
- A mental health assessment by the deployed mental health team, dated 3 September 2013;
- An incident report and outpatient health record by the medical officer, dated 11 August 2016;
- A CT coronary angiogram report and consultation by the cardiologist, dated 6 October 2016;
- A psychiatric review by the consultant psychiatrist, dated 6 October 2016.

Your service

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

19 July 2004 and 14 December 2018

Chest - Anxiety - related Chest Pain

You have stated that your condition was caused by:

- *having a clinically significant anxiety disorder, including panic disorder, at the time of the clinical onset of anxiety-related chest pain*
- *experiencing a category 1A stressor within the 5 years before the clinical onset of anxiety-related chest pain*
- *having posttraumatic stress disorder at the time of the clinical onset of anxiety-related chest pain*
- *having a clinically significant depressive disorder at the time of the clinical onset of anxiety-related chest pain*
- *being exposed to sustained high-demand, high-responsibility occupational stress, including shift work and the threat of hostile action, for at least the 6 months before the clinical onset of anxiety-related chest pain*
- *having a breathing pattern disorder or chronic hyperventilation at the time of the clinical onset of anxiety-related chest pain*
- *consuming at least 400 milligrams of caffeine per day for at least the 4 weeks before the clinical onset of anxiety-related chest pain*
- *taking a sympathomimetic medication, including pseudoephedrine or an inhaled beta-agonist, within the 30 days before the clinical onset of anxiety-related chest pain*
- *experiencing withdrawal from alcohol or a benzodiazepine within the 7 days before the clinical onset of anxiety-related chest pain*
- *having gastro-oesophageal reflux disease or oesophageal hypersensitivity at the time of the clinical onset of anxiety-related chest pain*
- *experiencing sleep deprivation, with an average of less than 5 hours of sleep per day, for at least the 7 days before the clinical onset of anxiety-related chest pain*

Diagnosis: Anxiety - related Chest Pain

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 2 April 2025, and is supported by a consultation (chest X-ray and stress echocardiogram reports) by the senior medical officer, dated 24 April 2013.

I am satisfied this is the appropriate diagnosis.
There is no Statement of Principles (SOP) for this condition. In determining your claim for this condition, I have therefore considered the available evidence, applying the standard of proof:

Reasonable Hypothesis - no Statement of Principles determined for this condition

which requires the evidence to connect the condition with service.

I am satisfied that the evidence establishes the following link to your service:

- *having a clinically significant anxiety disorder, including panic disorder, at the time of the clinical onset of anxiety-related chest pain*
- *experiencing a category 1A stressor within the 5 years before the clinical onset of anxiety-related chest pain*
- *having posttraumatic stress disorder at the time of the clinical onset of anxiety-related chest pain*
- *having a clinically significant depressive disorder at the time of the clinical onset of anxiety-related chest pain*
- *being exposed to sustained high-demand, high-responsibility occupational stress, including shift work and the threat of hostile action, for at least the 6 months before the clinical onset of anxiety-related chest pain*
- *having a breathing pattern disorder or chronic hyperventilation at the time of the clinical onset of anxiety-related chest pain*
- *consuming at least 400 milligrams of caffeine per day for at least the 4 weeks before the clinical onset of anxiety-related chest pain*
- *taking a sympathomimetic medication, including pseudoephedrine or an inhaled beta-agonist, within the 30 days before the clinical onset of anxiety-related chest pain*
- *experiencing withdrawal from alcohol or a benzodiazepine within the 7 days before the clinical onset of anxiety-related chest pain*
- *having gastro-oesophageal reflux disease or oesophageal hypersensitivity at the time of the clinical onset of anxiety-related chest pain*
- *experiencing sleep deprivation, with an average of less than 5 hours of sleep per day, for at least the 7 days before the clinical onset of anxiety-related chest pain*

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 sudden episodes of central chest tightness and sharp left-sided chest pain, palpitations, breathlessness, tingling in the hands, sweating and an intense fear of dying, each lasting 15 to 45 minutes and often waking you from sleep or occurring after indirect-fire alarms on 22 March 2013.

The diagnosis was made by the senior medical officer on 24 April 2013 and confirmed by the deployed mental health team on 3 September 2013 and by a psychiatrist and cardiologist in October 2016. The episodes have the typical features of panic attacks, with sudden chest tightness, palpitations, breathlessness, paraesthesiae and fear of dying, in a person with established panic disorder, PTSD and a dysfunctional breathing pattern.

This has then led to further investigations and the diagnosis of your condition of *Anxiety - related Chest Pain*. I have accepted your condition of *Anxiety - related Chest Pain*.

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

I have therefore accepted that this condition is related to your service with effect from 22 March 2013.

Chest - Anxiety - related Chest Pain (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 2 April 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 2 April 2025;
- An incident report and treatment record by Role 2 facility, Afghanistan, dated 14 July 2009;
- A psychiatric assessment by the consultant psychiatrist, dated 9 March 2011;
- A gastroscopy report by the gastroenterologist, dated 9 March 2011;
- A psychiatric review by the consultant psychiatrist, dated 21 August 2012;
- A physiotherapy breathing assessment by the physiotherapist, dated 21 August 2012;
- A treatment record and ECG by the medical officer, Middle East Area of Operations, dated 22 March 2013;
- A consultation (chest X-ray and stress echocardiogram reports) by the senior medical officer, dated 24 April 2013;
- A mental health assessment by the deployed mental health team, dated 3 September 2013;
- An incident report and outpatient health record by the medical officer, dated 11 August 2016;
- A CT coronary angiogram report and consultation by the cardiologist, dated 6 October 2016;
- A psychiatric review by the consultant psychiatrist, dated 6 October 2016.

Your service

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

19 July 2004 and 14 December 2018

Chest - Anxiety - related Chest Pain (Worsening)

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

- *experiencing a severe traumatic or stressful event within the 6 months before the clinical worsening of anxiety-related chest pain*

- *ceasing or interrupting treatment with an antidepressant or anxiolytic medication within the 30 days before the clinical worsening of anxiety-related chest pain*
- *consuming at least 400 milligrams of caffeine per day for at least the 4 weeks before the clinical worsening of anxiety-related chest pain*
- *experiencing sleep deprivation, with an average of less than 5 hours of sleep per day, for at least the 7 days before the clinical worsening of anxiety-related chest pain*
- *inability to obtain appropriate clinical management for anxiety-related chest pain*

Diagnosis: Anxiety - related Chest Pain (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 2 April 2025, and is supported by a consultation (chest X-ray and stress echocardiogram reports) by the senior medical officer, dated 24 April 2013.

I am satisfied this is the appropriate diagnosis.
There is no Statement of Principles (SOP) for this condition. In determining your claim for this condition, I have therefore considered the available evidence, applying the standard of proof:

Balance of Probabilities (reasonable satisfaction) - no Statement of Principles determined for this condition

which requires the evidence to connect the condition with service.

I am satisfied that the evidence establishes the following link to your service:

- *experiencing a severe traumatic or stressful event within the 6 months before the clinical worsening of anxiety-related chest pain*
- *ceasing or interrupting treatment with an antidepressant or anxiolytic medication within the 30 days before the clinical worsening of anxiety-related chest pain*
- *consuming at least 400 milligrams of caffeine per day for at least the 4 weeks before the clinical worsening of anxiety-related chest pain*
- *experiencing sleep deprivation, with an average of less than 5 hours of sleep per day, for at least the 7 days before the clinical worsening of anxiety-related chest pain*
- *inability to obtain appropriate clinical management for anxiety-related chest pain*

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 sudden episodes of central chest tightness and sharp left-sided chest pain, palpitations, breathlessness, tingling in the hands, sweating and an intense fear of dying, each lasting 15 to 45 minutes and often waking you from sleep or occurring after indirect-fire alarms on 22 March 2013.

The diagnosis was made by the senior medical officer on 24 April 2013 and confirmed by the deployed mental health team on 3 September 2013 and by a psychiatrist and cardiologist in October 2016. The episodes have the typical features of panic attacks, with sudden chest

tightness, palpitations, breathlessness, paraesthesiae and fear of dying, in a person with established panic disorder, PTSD and a dysfunctional breathing pattern.

After the condition arose, it was worsened during your service. On 11 August 2016, in peacetime service in Australia, you were first responder at a training accident in which a soldier was crushed under a vehicle and died at the scene. Your sertraline 150 mg daily ran out on 25 July 2016 during a field exercise and could not be replaced for three weeks. Through mid-2016, including the field exercise, you drank about 600 milligrams of caffeine a day from energy drinks and coffee, recorded by the psychiatrist on 6 October 2016. During the field exercise from late July 2016 and in the weeks after the fatal accident you slept about four to five hours a night, with nightmares of the scene. On warlike service in 2013 psychological therapy for your panic attacks with chest pain was not available and was deferred until your return to Australia, and in 2016 your sertraline was not replaced for three weeks.

This has then led to further investigations and the diagnosis of your condition of *Anxiety - related Chest Pain (Worsening)*. I have accepted your condition of *Anxiety - related Chest Pain (Worsening)*.

Having considered your service records and the available medical evidence, I am satisfied the evidence establishes 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 11 August 2016.

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.