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.

Convergence Insufficiency

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 22 May 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 22 May 2025;
- A pre-deployment eye examination by the optometrist, dated 4 November 2009;
- An emergency treatment record and CT report by Role 2 facility, Afghanistan, dated 2 June 2010;
- An outpatient health record by the medical officer, Role 1 health facility, Afghanistan, dated 8 June 2010;
- An outpatient health record by the medical officer, Role 1 health facility, Afghanistan, dated 20 July 2010;
- A binocular vision assessment by the optometrist, dated 30 November 2010;
- An emergency department record by the medical officer, Garrison health centre, dated 16 August 2018;
- A neurology consultation and dopamine transporter SPECT by the neurologist, dated 11 June 2019;
- A diagnostic polysomnography report by the sleep physician, dated 21 June 2019;
- An MRI brain by the radiologist, dated 28 June 2019;
- A binocular vision review by the optometrist, dated 14 March 2020.

Your service

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

11 January 2000 and 19 March 2021

Convergence Insufficiency

You have stated that your condition was caused by:

- *sustaining a traumatic brain injury, including a mild traumatic brain injury or concussion, within the 1 year before the clinical onset of convergence insufficiency*
- *being exposed to blast overpressure from the firing of artillery, mortars or other heavy weapons, or from explosive detonations, on at least 100 occasions within the 5 years before the clinical onset of convergence insufficiency*
- *sustaining an acceleration-deceleration (whiplash) injury of the cervical spine within the 1 year before the clinical onset of convergence insufficiency*
- *performing sustained near-vision work, including work on computer screens, digital displays or optical instruments, for an average of at least 6 hours per day on more days than not for at least the 6 months before the clinical onset of convergence insufficiency*
- *taking a drug with significant anticholinergic or sedative effects, including a tricyclic antidepressant, benzodiazepine or antipsychotic, for at least the 1 month before the clinical onset of convergence insufficiency*

Diagnosis: Convergence Insufficiency

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 22 May 2025, and is supported by a binocular vision assessment by the optometrist, dated 30 November 2010.

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:

- *sustaining a traumatic brain injury, including a mild traumatic brain injury or concussion, within the 1 year before the clinical onset of convergence insufficiency*
- *being exposed to blast overpressure from the firing of artillery, mortars or other heavy weapons, or from explosive detonations, on at least 100 occasions within the 5 years before the clinical onset of convergence insufficiency*
- *sustaining an acceleration-deceleration (whiplash) injury of the cervical spine within the 1 year before the clinical onset of convergence insufficiency*
- *performing sustained near-vision work, including work on computer screens, digital displays or optical instruments, for an average of at least 6 hours per day on more days than not for at least the 6 months before the clinical onset of convergence insufficiency*

- *taking a drug with significant anticholinergic or sedative effects, including a tricyclic antidepressant, benzodiazepine or antipsychotic, for at least the 1 month before the clinical onset of convergence insufficiency*

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 eye strain, blurred and doubled print at near, frontal headache after short periods of close work, losing your place when reading maps and screens, and difficulty concentrating on detailed tasks on 20 July 2010.

The diagnosis was confirmed by an optometrist on 30 November 2010 on a formal binocular vision assessment: a near point of convergence of 16 cm break and 20 cm recovery (normal less than 6 to 10 cm), an exophoria of 10 prism dioptres at near and only 2 at distance, reduced positive fusional vergence at near failing Sheard's criterion, and a Convergence Insufficiency Symptom Survey score of 38 (symptomatic above 16). Visual acuity, refraction and ocular health were normal, so the symptoms were not due to refractive error or eye disease.

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

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 15 July 2010.

Convergence Insufficiency (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 22 May 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 22 May 2025;
- A pre-deployment eye examination by the optometrist, dated 4 November 2009;
- An emergency treatment record and CT report by Role 2 facility, Afghanistan, dated 2 June 2010;
- An outpatient health record by the medical officer, Role 1 health facility, Afghanistan, dated 8 June 2010;
- An outpatient health record by the medical officer, Role 1 health facility, Afghanistan, dated 20 July 2010;
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- A neurology consultation and dopamine transporter SPECT by the neurologist, dated 11 June 2019;
- A diagnostic polysomnography report by the sleep physician, dated 21 June 2019;
- An MRI brain by the radiologist, dated 28 June 2019;
- A binocular vision review by the optometrist, dated 14 March 2020.

Your service

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

11 January 2000 and 19 March 2021

Convergence Insufficiency (Worsening)

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

- *sustaining a further traumatic brain injury, including a mild traumatic brain injury or concussion, before the clinical worsening of convergence insufficiency*

- *having Parkinson's disease at the time of the clinical worsening of convergence insufficiency*
- *performing sustained near-vision work, including work on computer screens, digital displays or optical instruments, for an average of at least 6 hours per day on more days than not for at least the 6 months before the clinical worsening of convergence insufficiency*
- *taking a drug with significant anticholinergic or sedative effects, including a tricyclic antidepressant, benzodiazepine or antipsychotic, for at least the 1 month before the clinical worsening of convergence insufficiency*
- *having a sleep disorder causing chronic sleep deprivation, including insomnia disorder or obstructive sleep apnoea, at the time of the clinical worsening of convergence insufficiency*
- *inability to obtain appropriate clinical management for convergence insufficiency*

Diagnosis: Convergence Insufficiency (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 22 May 2025, and is supported by a binocular vision assessment by the optometrist, dated 30 November 2010.

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:

- *sustaining a further traumatic brain injury, including a mild traumatic brain injury or concussion, before the clinical worsening of convergence insufficiency*
- *having Parkinson's disease at the time of the clinical worsening of convergence insufficiency*
- *performing sustained near-vision work, including work on computer screens, digital displays or optical instruments, for an average of at least 6 hours per day on more days than not for at least the 6 months before the clinical worsening of convergence insufficiency*
- *taking a drug with significant anticholinergic or sedative effects, including a tricyclic antidepressant, benzodiazepine or antipsychotic, for at least the 1 month before the clinical worsening of convergence insufficiency*
- *having a sleep disorder causing chronic sleep deprivation, including insomnia disorder or obstructive sleep apnoea, at the time of the clinical worsening of convergence insufficiency*
- *inability to obtain appropriate clinical management for convergence insufficiency*

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 eye strain, blurred and doubled print at near, frontal headache after short periods of close work, losing your place when reading maps and screens, and difficulty concentrating on detailed tasks on 20 July 2010.

The diagnosis was confirmed by an optometrist on 30 November 2010 on a formal binocular vision assessment: a near point of convergence of 16 cm break and 20 cm recovery (normal less than 6 to 10 cm), an exophoria of 10 prism dioptres at near and only 2 at distance, reduced positive fusional vergence at near failing Sheard's criterion, and a Convergence Insufficiency Symptom Survey score of 38 (symptomatic above 16). Visual acuity, refraction and ocular health were normal, so the symptoms were not due to refractive error or eye disease.

After the condition arose, it was worsened during your service. On 16 August 2018, during a field exercise in Australia, you fell from the rear deck of an armoured vehicle and struck your head, with brief loss of consciousness and about one hour of post-traumatic amnesia. A neurologist diagnosed young-onset Parkinson's disease on 11 June 2019, confirmed by dopamine transporter imaging on 5 June 2019, and it was present at the worsening on 14 March 2020. From 2018 you worked in an intelligence staff role, analysing imagery and reports on screens for 8 to 10 hours a day. Amitriptyline, increased to 50 mg at night in 2016 for persisting post-traumatic headache, was taken continuously throughout the 1 month before the worsening, from 14 February 2020 to 14 March 2020. Polysomnography in June 2019 showed moderate obstructive sleep apnoea with an apnoea-hypopnoea index of 24, and you reported chronic sleep loss averaging 5 hours a night from shift work and post-traumatic headache. Office-based vergence therapy, the treatment with the strongest evidence for convergence insufficiency, was recommended by the optometrist on 30 November 2010 but was not funded through Defence health and was never provided.

This has then led to further investigations and the diagnosis of your condition of *Convergence Insufficiency (Worsening)*. I have accepted your condition of *Convergence Insufficiency (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 14 March 2020.

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