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.

Hypertension

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 10 November 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 10 November 2025;
- Deployment works and hazardous materials records by the engineer unit, East Timor, dated 15 November 1999;
- A hazardous chemical sampling report by the environmental health officer, Iraq, dated 22 May 2003;
- A haematology consultation by the haematologist, dated 12 March 2006;
- A transplant discharge summary by the transplant haematologist, dated 1 March 2007;
- An endocrinology consultation by the endocrinologist, dated 15 September 2007;
- A dermatology consultation by the dermatologist, dated 10 June 2008;
- A trauma admission and operation reports by Role 3 hospital, Afghanistan, dated 14 June 2010;
- A psychiatric assessment by the consultant psychiatrist, dated 5 April 2011;
- CT angiography renal arteries by the radiologist, dated 5 September 2011;
- A diagnostic polysomnography report by the sleep physician, dated 22 November 2011;
- A deployed health record by the medical officer, Kabul, dated 10 September 2012;
- A cardiopulmonary exercise test by the rehabilitation physician, dated 14 August 2013;
- An infectious diseases consultation by the infectious diseases physician, dated 20 September 2013;
- A haematology consultation by the haematologist, dated 6 November 2013;
- An outpatient health record by the medical officer, Garrison health centre, dated 18 December 2013;

- A dietetic assessment and CT angiography by the dietitian and radiologist, dated 20 December 2013;
- An ambulatory blood pressure report by the renal physician, dated 8 January 2014;
- An ambulatory blood pressure report and echocardiogram by the cardiologist, dated 12 February 2014;
- An ophthalmology consultation by the ophthalmologist, dated 12 February 2014.

Your service

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

20 January 1993 and 12 June 2015

Hypertension

You have stated that your condition was caused by:

- *being overweight or obese for at least the 5 years before the clinical onset of hypertension*
- *consuming an average of at least 400 grams of alcohol per week for a continuous period of at least the 6 months before the clinical onset of hypertension*
- *consuming an average of at least 12 grams (200 millimoles) of salt per day for at least the 1 year before the clinical onset of hypertension*
- *having renal artery stenosis at the time of the clinical onset of hypertension*
- *having a solid organ, stem cell or bone marrow transplant before the clinical onset of hypertension*
- *having diabetes mellitus for at least the 5 years before the clinical onset of hypertension*
- *having chronic kidney disease at the time of the clinical onset of hypertension*
- *having an endocrine disorder from the specified list of endocrine disorders at the time of the clinical onset of hypertension*
- *having sleep apnoea at the time of the clinical onset of hypertension*
- *having extrinsic compression of the renal parenchyma from a haematoma or mass at the time of the clinical onset of hypertension*
- *having: (a) an aneurysm of the renal artery; or (b) an arteriovenous fistula involving the blood supply of the kidney; or (c) an arteriovenous malformation involving the blood supply of the kidney; before the clinical onset of hypertension*
- *having a clinically significant disorder of mental health as specified at the time of the clinical onset of hypertension*
- *taking a drug from the Specified List 1 of drugs, where that drug cannot be ceased or substituted, for a continuous period of at least the 28 days before the clinical onset of hypertension*

- *taking a drug from the Specified List 2 of drugs at the time of the clinical onset of hypertension*
- *having glucocorticoid therapy as specified before the clinical onset of hypertension, and if the glucocorticoid therapy as specified has ceased or decreased before the clinical onset of hypertension, then that onset occurred within 30 days of cessation or reduction of therapy*
- *taking medroxyprogesterone acetate or megestrol acetate for a malignant disease or human immunodeficiency virus infection: (a) for at least 28 days before the clinical onset of hypertension; and (b) if treatment has ceased before the clinical onset of hypertension, then that onset occurred within 30 days of cessation*
- *inability to undertake any physical activity greater than 3 METs for at least the 1 year before the clinical onset of hypertension*
- *being exposed to arsenic as specified before the clinical onset of hypertension*

Diagnosis: Hypertension

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 10 November 2025, and is supported by an ambulatory blood pressure report by the renal physician, dated 8 January 2014.

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

Statement of Principles concerning Hypertension (Balance of Probabilities) (No. 22 of 2022)

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

I am satisfied that you have met the following factor:

- *being overweight or obese for at least the 5 years before the clinical onset of hypertension*
- *consuming an average of at least 400 grams of alcohol per week for a continuous period of at least the 6 months before the clinical onset of hypertension*
- *consuming an average of at least 12 grams (200 millimoles) of salt per day for at least the 1 year before the clinical onset of hypertension*
- *having renal artery stenosis at the time of the clinical onset of hypertension*
- *having a solid organ, stem cell or bone marrow transplant before the clinical onset of hypertension*
- *having diabetes mellitus for at least the 5 years before the clinical onset of hypertension*
- *having chronic kidney disease at the time of the clinical onset of hypertension*
- *having an endocrine disorder from the specified list of endocrine disorders at the time of the clinical onset of hypertension*
- *having sleep apnoea at the time of the clinical onset of hypertension*
- *having extrinsic compression of the renal parenchyma from a haematoma or mass at the time of the clinical onset of hypertension*

- *having: (a) an aneurysm of the renal artery; or (b) an arteriovenous fistula involving the blood supply of the kidney; or (c) an arteriovenous malformation involving the blood supply of the kidney; before the clinical onset of hypertension*
- *having a clinically significant disorder of mental health as specified at the time of the clinical onset of hypertension*
- *taking a drug from the Specified List 1 of drugs, where that drug cannot be ceased or substituted, for a continuous period of at least the 28 days before the clinical onset of hypertension*
- *taking a drug from the Specified List 2 of drugs at the time of the clinical onset of hypertension*
- *having glucocorticoid therapy as specified before the clinical onset of hypertension, and if the glucocorticoid therapy as specified has ceased or decreased before the clinical onset of hypertension, then that onset occurred within 30 days of cessation or reduction of therapy*
- *taking medroxyprogesterone acetate or megestrol acetate for a malignant disease or human immunodeficiency virus infection: (a) for at least 28 days before the clinical onset of hypertension; and (b) if treatment has ceased before the clinical onset of hypertension, then that onset occurred within 30 days of cessation*
- *inability to undertake any physical activity greater than 3 METs for at least the 1 year before the clinical onset of hypertension*
- *being exposed to arsenic as specified before the clinical onset of hypertension*

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 occipital headaches on waking, blurred vision, palpitations and a sense of pressure in the head on 18 December 2013.

The diagnosis was made by the renal physician on ambulatory blood pressure monitoring on 8 January 2014, which showed a 24-hour average of 156/98 mmHg and a daytime average of 161/101 mmHg, exceeding the equivalent ambulatory levels in the Statement of Principles, after clinic readings of 172/104, 168/102 and 170/106 mmHg on 18 December 2013. Regular antihypertensive therapy was started. The persistent elevation is not a temporary rise from acute renal failure or medication alone, so the exclusion does not apply.

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

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 15 December 2013.

Hypertension (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 10 November 2025;
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- Deployment works and hazardous materials records by the engineer unit, East Timor, dated 15 November 1999;
- A hazardous chemical sampling report by the environmental health officer, Iraq, dated 22 May 2003;
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- A transplant discharge summary by the transplant haematologist, dated 1 March 2007;
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- A dermatology consultation by the dermatologist, dated 10 June 2008;
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- A cardiopulmonary exercise test by the rehabilitation physician, dated 14 August 2013;
- An infectious diseases consultation by the infectious diseases physician, dated 20 September 2013;
- A haematology consultation by the haematologist, dated 6 November 2013;
- An outpatient health record by the medical officer, Garrison health centre, dated 18 December 2013;
- A dietetic assessment and CT angiography by the dietitian and radiologist, dated 20 December 2013;
- An ambulatory blood pressure report by the renal physician, dated 8 January 2014;
- An ambulatory blood pressure report and echocardiogram by the cardiologist, dated 12 February 2014;
- An ophthalmology consultation by the ophthalmologist, dated 12 February 2014.

Your service

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

20 January 1993 and 12 June 2015

Hypertension (Worsening)

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

- *being overweight or obese for at least the 5 years before the clinical worsening of hypertension*
- *consuming an average of at least 400 grams of alcohol per week for a continuous period of at least the 6 months before the clinical worsening of hypertension*
- *consuming an average of at least 12 grams (200 millimoles) of salt per day for at least the 1 year before the clinical worsening of hypertension*
- *having renal artery stenosis at the time of the clinical worsening of hypertension*
- *having a solid organ, stem cell or bone marrow transplant before the clinical worsening of hypertension*
- *having diabetes mellitus for at least the 5 years before the clinical worsening of hypertension*
- *having chronic kidney disease at the time of the clinical worsening of hypertension*
- *having an endocrine disorder from the specified list of endocrine disorders at the time of the clinical worsening of hypertension*
- *having sleep apnoea at the time of the clinical worsening of hypertension*
- *having extrinsic compression of the renal parenchyma from a haematoma or mass at the time of the clinical worsening of hypertension*
- *having: (a) an aneurysm of the renal artery; or (b) an arteriovenous fistula involving the blood supply of the kidney; or (c) an arteriovenous malformation involving the blood supply of the kidney; before the clinical worsening of hypertension*
- *having a clinically significant disorder of mental health as specified at the time of the clinical worsening of hypertension*
- *taking a drug from the Specified List 1 of drugs, where that drug cannot be ceased or substituted, for a continuous period of at least the 28 days before the clinical worsening of hypertension*
- *taking a drug from the Specified List 2 of drugs at the time of the clinical worsening of hypertension*
- *having glucocorticoid therapy as specified before the clinical worsening of hypertension, and if the glucocorticoid therapy as specified has ceased or decreased before the clinical worsening of hypertension, then that worsening occurred within 30 days of cessation or reduction of therapy*

- *taking medroxyprogesterone acetate or megestrol acetate for a malignant disease or human immunodeficiency virus infection: (a) for at least 28 days before the clinical worsening of hypertension; and (b) if treatment has ceased before the clinical worsening of hypertension, then that worsening occurred within 30 days of cessation*
- *inability to undertake any physical activity greater than 3 METs for at least the 1 year before the clinical worsening of hypertension*
- *being exposed to arsenic as specified before the clinical worsening of hypertension*
- *inability to obtain appropriate clinical management for hypertension*

Diagnosis: Hypertension (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 10 November 2025, and is supported by an ambulatory blood pressure report by the renal physician, dated 8 January 2014.

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

Statement of Principles concerning Hypertension (Balance of Probabilities) (No. 22 of 2022)

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

I am satisfied that you have met the following factor:

- *being overweight or obese for at least the 5 years before the clinical worsening of hypertension*
- *consuming an average of at least 400 grams of alcohol per week for a continuous period of at least the 6 months before the clinical worsening of hypertension*
- *consuming an average of at least 12 grams (200 millimoles) of salt per day for at least the 1 year before the clinical worsening of hypertension*
- *having renal artery stenosis at the time of the clinical worsening of hypertension*
- *having a solid organ, stem cell or bone marrow transplant before the clinical worsening of hypertension*
- *having diabetes mellitus for at least the 5 years before the clinical worsening of hypertension*
- *having chronic kidney disease at the time of the clinical worsening of hypertension*
- *having an endocrine disorder from the specified list of endocrine disorders at the time of the clinical worsening of hypertension*
- *having sleep apnoea at the time of the clinical worsening of hypertension*
- *having extrinsic compression of the renal parenchyma from a haematoma or mass at the time of the clinical worsening of hypertension*
- *having: (a) an aneurysm of the renal artery; or (b) an arteriovenous fistula involving the blood supply of the kidney; or (c) an arteriovenous malformation involving the blood*

supply of the kidney; before the clinical worsening of hypertension

- *having a clinically significant disorder of mental health as specified at the time of the clinical worsening of hypertension*
- *taking a drug from the Specified List 1 of drugs, where that drug cannot be ceased or substituted, for a continuous period of at least the 28 days before the clinical worsening of hypertension*
- *taking a drug from the Specified List 2 of drugs at the time of the clinical worsening of hypertension*
- *having glucocorticoid therapy as specified before the clinical worsening of hypertension, and if the glucocorticoid therapy as specified has ceased or decreased before the clinical worsening of hypertension, then that worsening occurred within 30 days of cessation or reduction of therapy*
- *taking medroxyprogesterone acetate or megestrol acetate for a malignant disease or human immunodeficiency virus infection: (a) for at least 28 days before the clinical worsening of hypertension; and (b) if treatment has ceased before the clinical worsening of hypertension, then that worsening occurred within 30 days of cessation*
- *inability to undertake any physical activity greater than 3 METs for at least the 1 year before the clinical worsening of hypertension*
- *being exposed to arsenic as specified before the clinical worsening of hypertension*
- *inability to obtain appropriate clinical management for hypertension*

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 occipital headaches on waking, blurred vision, palpitations and a sense of pressure in the head on 18 December 2013.

The diagnosis was made by the renal physician on ambulatory blood pressure monitoring on 8 January 2014, which showed a 24-hour average of 156/98 mmHg and a daytime average of 161/101 mmHg, exceeding the equivalent ambulatory levels in the Statement of Principles, after clinic readings of 172/104, 168/102 and 170/106 mmHg on 18 December 2013. Regular antihypertensive therapy was started. The persistent elevation is not a temporary rise from acute renal failure or medication alone, so the exclusion does not apply.

After the condition arose, it was worsened during your service. You remained overweight, with a BMI of 30.1 and waist of 110 cm on 12 February 2014, and had been overweight or obese throughout the 5 years before the worsening, from 12 February 2009 to 12 February 2014. You drank an average of about 45 standard drinks, 450 grams of alcohol, a week throughout the 6 months before the worsening, from 12 August 2013 to 12 February 2014. Your salt intake of about 14 grams a day, including the sodium in effervescent paracetamol, continued throughout the 1 year before the worsening, from 12 February 2013 to 12 February 2014. The 70 per cent stenosis of the left renal artery remained present, unrevascularised, at the worsening on 12 February 2014. The stem cell transplant of 1 March 2007 preceded the worsening on 12 February 2014. Post-transplant diabetes mellitus had been present continuously since September 2007,

more than 5 years before the worsening on 12 February 2014. Chronic kidney disease persisted, with an eGFR of 34 mL/min/1.73 m2 on 12 February 2014, at the worsening. Hypothyroidism remained present and under-replaced, with a TSH of 7.2 mU/L on 10 February 2014, at the worsening. Obstructive sleep apnoea, untreated because CPAP could not be tolerated, was present at the worsening on 12 February 2014. The organised subcapsular haematoma continued to compress the left renal parenchyma at the worsening on 12 February 2014. The renal artery pseudoaneurysm, the arteriovenous fistula and the arteriovenous malformation were all present before the worsening on 12 February 2014. Posttraumatic stress disorder, under monthly psychiatric management, was present at the worsening, with increased nightmares and arousal recorded in January 2014. Itraconazole, which could not be ceased or substituted, was taken continuously throughout the 28 days before the worsening, from 15 January to 12 February 2014. Darbepoetin alfa continued weekly and was being taken at the worsening on 12 February 2014. Inhaled fluticasone with itraconazole continued daily, without reduction, up to the worsening on 12 February 2014. Megestrol acetate 160 mg daily for the relapsed leukaemia continued from 8 November 2013 to beyond the worsening, more than 28 days before 12 February 2014, without cessation. The inability to undertake any activity above 3 METs continued throughout the 1 year before the worsening, from 12 February 2013 to 12 February 2014. The clinical evidence of chronic arsenic toxicity persisted, with further arsenic trioxide from 8 November 2013, before the worsening on 12 February 2014. After onset your blood pressure could not be adequately managed.

This has then led to further investigations and the diagnosis of your condition of *Hypertension (Worsening)*. I have accepted your condition of *Hypertension (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 12 February 2014.

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.