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.

Idiopathic Hypersomnolence

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 25 June 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 25 June 2025;
- A periodic health examination by the medical officer, Garrison health centre, dated 14 June 2011;
- An incident report and outpatient health record by the medical officer, Afghanistan, dated 14 August 2012;
- An outpatient health record and heterophile antibody test by Role 2 facility, Afghanistan, dated 21 September 2012;
- A post-deployment health assessment by the medical officer, dated 6 December 2012;
- An outpatient health record and influenza PCR by the medical officer, Garrison health centre, dated 22 January 2013;
- An operation and anaesthetic record by the orthopaedic surgeon and anaesthetist, dated 16 April 2013;
- A psychiatric assessment by the consultant psychiatrist, dated 20 May 2013;
- An outpatient health record by the medical officer, Garrison health centre, dated 5 August 2013;
- An MRI brain by the radiologist, dated 28 August 2013;
- A polysomnography (multiple sleep latency test and sleep consultation) by the sleep physician, dated 12 March 2014;
- An outpatient health record by the medical officer, Middle East, dated 10 September 2018;
- A repeat multiple sleep latency test and specialist review by the sleep physician, dated 28 February 2019.

Your service

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

8 February 2007 and 27 August 2020

Idiopathic Hypersomnolence

You have stated that your condition was caused by:

- *having infectious mononucleosis or other laboratory-confirmed Epstein-Barr virus infection within the 12 months before the clinical onset of idiopathic hypersomnolence*
- *having a systemic viral infection, including laboratory-confirmed influenza, within the 12 months before the clinical onset of idiopathic hypersomnolence*
- *having a mild traumatic brain injury within the 2 years before the clinical onset of idiopathic hypersomnolence*
- *undergoing general anaesthesia within the 3 months before the clinical onset of idiopathic hypersomnolence*
- *working rotating shifts that include night work for at least the 12 months before the clinical onset of idiopathic hypersomnolence*
- *having chronic insufficient sleep, averaging less than 6 hours of sleep per night, for at least the 6 months before the clinical onset of idiopathic hypersomnolence*
- *having depressive disorder at the time of the clinical onset of idiopathic hypersomnolence*
- *having posttraumatic stress disorder at the time of the clinical onset of idiopathic hypersomnolence*

Diagnosis: Idiopathic Hypersomnolence

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 25 June 2025, and is supported by a polysomnography (multiple sleep latency test and sleep consultation) by the sleep physician, dated 12 March 2014.

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:

- *having infectious mononucleosis or other laboratory-confirmed Epstein-Barr virus infection within the 12 months before the clinical onset of idiopathic hypersomnolence*

- *having a systemic viral infection, including laboratory-confirmed influenza, within the 12 months before the clinical onset of idiopathic hypersomnolence*
- *having a mild traumatic brain injury within the 2 years before the clinical onset of idiopathic hypersomnolence*
- *undergoing general anaesthesia within the 3 months before the clinical onset of idiopathic hypersomnolence*
- *working rotating shifts that include night work for at least the 12 months before the clinical onset of idiopathic hypersomnolence*
- *having chronic insufficient sleep, averaging less than 6 hours of sleep per night, for at least the 6 months before the clinical onset of idiopathic hypersomnolence*
- *having depressive disorder at the time of the clinical onset of idiopathic hypersomnolence*
- *having posttraumatic stress disorder at the time of the clinical onset of idiopathic hypersomnolence*

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 excessive daytime sleepiness despite sleeping 11 to 12 hours a night, waking unrefreshed, profound difficulty waking with confusion and clumsiness for up to an hour (sleep drunkenness), and long naps of two to three hours that did not refresh you on 5 August 2013.

The diagnosis was confirmed on 12 March 2014 by a sleep physician on the basis of polysomnography with extended 24-hour recording showing a total sleep time of 12 hours 40 minutes, and a multiple sleep latency test showing a mean sleep latency of 6.5 minutes with only one sleep-onset REM period. These results meet the International Classification of Sleep Disorders (third edition) criteria for idiopathic hypersomnia: daily excessive sleepiness for more than three months, no cataplexy, fewer than two sleep-onset REM periods, and objective evidence of hypersomnolence on both measures.

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

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

I have therefore accepted that this condition is related to your service with effect from 10 July 2013.

Idiopathic Hypersomnolence (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 25 June 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 25 June 2025;
- A periodic health examination by the medical officer, Garrison health centre, dated 14 June 2011;
- An incident report and outpatient health record by the medical officer, Afghanistan, dated 14 August 2012;
- An outpatient health record and heterophile antibody test by Role 2 facility, Afghanistan, dated 21 September 2012;
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- An MRI brain by the radiologist, dated 28 August 2013;
- A polysomnography (multiple sleep latency test and sleep consultation) by the sleep physician, dated 12 March 2014;
- An outpatient health record by the medical officer, Middle East, dated 10 September 2018;
- A repeat multiple sleep latency test and specialist review by the sleep physician, dated 28 February 2019.

Your service

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

8 February 2007 and 27 August 2020

Idiopathic Hypersomnolence (Worsening)

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

- *working night shifts or rotating shifts that include night work for at least the 3 months before the clinical worsening of idiopathic hypersomnolence*
- *having chronic insufficient sleep, averaging less than 6 hours of sleep per night, for at least the 3 months before the clinical worsening of idiopathic hypersomnolence*
- *having a mild traumatic brain injury within the 6 months before the clinical worsening of idiopathic hypersomnolence*
- *taking a sedating medication, including an antipsychotic, opioid or sedating antihistamine, for at least the 1 month before the clinical worsening of idiopathic hypersomnolence*
- *having depressive disorder or posttraumatic stress disorder at the time of the clinical worsening of idiopathic hypersomnolence*
- *inability to obtain appropriate clinical management for idiopathic hypersomnolence*

Diagnosis: Idiopathic Hypersomnolence (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 25 June 2025, and is supported by a polysomnography (multiple sleep latency test and sleep consultation) by the sleep physician, dated 12 March 2014.

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:

- *working night shifts or rotating shifts that include night work for at least the 3 months before the clinical worsening of idiopathic hypersomnolence*
- *having chronic insufficient sleep, averaging less than 6 hours of sleep per night, for at least the 3 months before the clinical worsening of idiopathic hypersomnolence*
- *having a mild traumatic brain injury within the 6 months before the clinical worsening of idiopathic hypersomnolence*
- *taking a sedating medication, including an antipsychotic, opioid or sedating antihistamine, for at least the 1 month before the clinical worsening of idiopathic hypersomnolence*
- *having depressive disorder or posttraumatic stress disorder at the time of the clinical worsening of idiopathic hypersomnolence*
- *inability to obtain appropriate clinical management for idiopathic hypersomnolence*

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 excessive daytime sleepiness despite sleeping 11 to 12 hours a night, waking unrefreshed, profound difficulty waking with confusion and clumsiness for up to an hour (sleep drunkenness), and long naps of two to three hours that did not refresh you on 5 August 2013.

The diagnosis was confirmed on 12 March 2014 by a sleep physician on the basis of polysomnography with extended 24-hour recording showing a total sleep time of 12 hours 40 minutes, and a multiple sleep latency test showing a mean sleep latency of 6.5 minutes with only one sleep-onset REM period. These results meet the International Classification of Sleep Disorders (third edition) criteria for idiopathic hypersomnia: daily excessive sleepiness for more than three months, no cataplexy, fewer than two sleep-onset REM periods, and objective evidence of hypersomnolence on both measures.

After the condition arose, it was worsened during your service. On non-warlike service in the Middle East you were rostered to 12-hour night shifts in the communications centre from April 2018, throughout the 3 months before the worsening from 15 June 2018 to 15 September 2018, despite a recommendation against shift work. In the Middle East daytime sleep after night shifts was disrupted by heat, noise in shared accommodation and alarms, and your sleep log averaged about five hours a day from 15 June 2018 to 15 September 2018. On 19 June 2018, on non-warlike service in the Middle East, you struck your head on a vehicle door frame when the vehicle braked sharply, with brief confusion and headache for several days, diagnosed as concussion by the medical officer. You took quetiapine 50 mg nightly, prescribed by your psychiatrist for posttraumatic stress disorder nightmares, throughout the month before the worsening and for the whole deployment. Posttraumatic stress disorder and major depressive disorder, both arising from your warlike service in Afghanistan, were active at the worsening, with a PCL-5 score of 52 and a PHQ-9 score of 18 recorded in the Middle East on 10 September 2018. On non-warlike service in the Middle East your modafinil supply ran out on 20 July 2018 and could not be replaced in theatre, no sleep physician was available, and your restriction against night shifts was not applied.

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

I have therefore accepted that the worsening of this condition is related to your service with effect from 15 September 2018.

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.