# 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.*

## Left Elbow - Ulnar Neuropathy

### 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 October 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 10 October 2025;
- A trauma admission and operation report by Role 3 hospital, Afghanistan, dated 22 June 2010;
- An MRI brain and stroke assessment by the neurologist, dated 24 June 2010;
- A renal biopsy report by the renal physician, dated 10 March 2014;
- A haemodialysis commencement by the renal physician, dated 5 August 2014;
- An endocrinology consultation by the endocrinologist, dated 20 April 2015;
- A burns unit discharge summary by the burns surgeon, dated 14 November 2015;
- A skin biopsy and specialist consultation by the infectious diseases physician, dated 18 January 2016;
- An X-ray left elbow and orthopaedic consultation by the orthopaedic surgeon, dated 12 June 2016;
- An elbow arthroscopy operation report by the orthopaedic surgeon, dated 26 July 2016;
- A pre-anaesthetic assessment by the anaesthetist, dated 28 September 2016;
- An operation report and discharge summary (caesarean section) by the obstetrician, dated 30 September 2016;
- An outpatient health record by the medical officer, Garrison health centre, dated 14 October 2016;
- A nerve conduction study and ultrasound by the neurologist, dated 2 November 2016;
- An operation report (ulnar nerve transposition) by the hand surgeon, dated 21 November 2016;

- A repeat nerve conduction study by the neurologist, dated 13 December 2016.

## Your service

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

15 January 2003 and 30 April 2018

## Left Elbow - Ulnar Neuropathy

You have stated that your condition was caused by:

- *having a fracture of the bones of the affected elbow, including fracture of the medial epicondyle of the humerus, before the clinical onset of ulnar neuropathy at the elbow*
- *having trauma to the affected elbow within the one year before the clinical onset of ulnar neuropathy at the elbow*
- *performing repetitive and forceful activities involving flexion and extension of the affected elbow: (a) for a cumulative period of at least 90 hours, within a continuous period of three months before the clinical onset of ulnar neuropathy at the elbow; and (b) where the repetitive and forceful activities have not ceased more than 30 days before the clinical onset of ulnar neuropathy at the elbow*
- *having a surgical procedure under general anaesthesia, within the one month before the clinical onset of ulnar neuropathy at the elbow*
- *having a surgical procedure to the affected elbow, including elbow arthroscopy, within the six months before the clinical onset of ulnar neuropathy at the elbow*
- *being hospitalised, or confined to bed in a supine position, for at least two days within the two weeks before the clinical onset of ulnar neuropathy at the elbow*
- *daily self-propulsion of a manual wheelchair: (a) for a cumulative period of at least 60 hours within a continuous period of three months before the clinical onset of ulnar neuropathy at the elbow; and (b) where this activity has not ceased more than 30 days before the clinical onset of ulnar neuropathy at the elbow*
- *having paraplegia at the time of the clinical onset of ulnar neuropathy at the elbow*
- *using elbow or forearm crutches: (a) for a cumulative period of at least 60 hours within a continuous period of three months before the clinical onset of ulnar neuropathy at the elbow; and (b) where this activity has not ceased more than 30 days before the clinical onset of ulnar neuropathy at the elbow*
- *having an inflammatory or degenerative joint disease from the specified list of specified list of inflammatory and degenerative joint diseases, involving the affected elbow, at the time of the clinical onset of ulnar neuropathy at the elbow*
- *having amyloidosis at the time of the clinical onset of ulnar neuropathy at the elbow*
- *having a cerebrovascular accident with hemiplegia, excluding transient ischaemic attack or transient symptoms with infarction, before the clinical onset of ulnar neuropathy at the*

*elbow*

- *having an external burn to the affected arm requiring hospitalisation, within the two years before the clinical onset of ulnar neuropathy at the elbow*
- *having an infection involving the affected ulnar nerve in the region of the elbow at the time of the clinical onset of ulnar neuropathy at the elbow*
- *having a lesion as specified at the elbow that compresses or displaces the affected ulnar nerve at the time of the clinical onset of ulnar neuropathy at the elbow*
- *having acromegaly before the clinical onset of ulnar neuropathy at the elbow*

**Diagnosis:** Ulnar Neuropathy

**Basis of diagnosis:** The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 10 October 2025, and is supported by a nerve conduction study and ultrasound by the neurologist, dated 2 November 2016.

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

*Statement of Principles concerning Ulnar Neuropathy at the Elbow (Balance of Probabilities) (No. 66 of 2017)*

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

I am satisfied that you have met the following factor:

- *having a fracture of the bones of the affected elbow, including fracture of the medial epicondyle of the humerus, before the clinical onset of ulnar neuropathy at the elbow*
- *having trauma to the affected elbow within the one year before the clinical onset of ulnar neuropathy at the elbow*
- *performing repetitive and forceful activities involving flexion and extension of the affected elbow: (a) for a cumulative period of at least 90 hours, within a continuous period of three months before the clinical onset of ulnar neuropathy at the elbow; and (b) where the repetitive and forceful activities have not ceased more than 30 days before the clinical onset of ulnar neuropathy at the elbow*
- *having a surgical procedure under general anaesthesia, within the one month before the clinical onset of ulnar neuropathy at the elbow*
- *having a surgical procedure to the affected elbow, including elbow arthroscopy, within the six months before the clinical onset of ulnar neuropathy at the elbow*
- *being hospitalised, or confined to bed in a supine position, for at least two days within the two weeks before the clinical onset of ulnar neuropathy at the elbow*
- *daily self-propulsion of a manual wheelchair: (a) for a cumulative period of at least 60 hours within a continuous period of three months before the clinical onset of ulnar neuropathy at the elbow; and (b) where this activity has not ceased more than 30 days before the clinical onset of ulnar neuropathy at the elbow*

- *having paraplegia at the time of the clinical onset of ulnar neuropathy at the elbow*
- *using elbow or forearm crutches: (a) for a cumulative period of at least 60 hours within a continuous period of three months before the clinical onset of ulnar neuropathy at the elbow; and (b) where this activity has not ceased more than 30 days before the clinical onset of ulnar neuropathy at the elbow*
- *having an inflammatory or degenerative joint disease from the specified list of specified list of inflammatory and degenerative joint diseases, involving the affected elbow, at the time of the clinical onset of ulnar neuropathy at the elbow*
- *having amyloidosis at the time of the clinical onset of ulnar neuropathy at the elbow*
- *having a cerebrovascular accident with hemiplegia, excluding transient ischaemic attack or transient symptoms with infarction, before the clinical onset of ulnar neuropathy at the elbow*
- *having an external burn to the affected arm requiring hospitalisation, within the two years before the clinical onset of ulnar neuropathy at the elbow*
- *having an infection involving the affected ulnar nerve in the region of the elbow at the time of the clinical onset of ulnar neuropathy at the elbow*
- *having a lesion as specified at the elbow that compresses or displaces the affected ulnar nerve at the time of the clinical onset of ulnar neuropathy at the elbow*
- *having acromegaly before the clinical onset of ulnar neuropathy at the elbow*

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 tingling and numbness of the left ring and little fingers and the ulnar side of the hand, worse when the elbow was bent, at night and when leaning on the elbow, with a weak grip and clumsiness with fine tools.Since the December 2016 worsening you have constant numbness in the ulnar distribution, wasting of the intrinsic hand muscles, clawing of the ring and little fingers and weak pinch on 14 October 2016.

The diagnosis was confirmed by nerve conduction studies on 2 November 2016, which showed slowing of left ulnar motor conduction across the elbow to 32 m/s compared with 54 m/s in the forearm, and a reduced ulnar sensory action potential, with normal median nerve studies. A neurologist confirmed ulnar neuropathy at the left elbow. With altered sensation and weakness in the ulnar distribution and electrodiagnostic evidence of impaired ulnar nerve function at the elbow, this meets the Statement of Principles definition.

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

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 12 October 2016.

# Left Elbow - Ulnar Neuropathy (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 October 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 10 October 2025;
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- An MRI brain and stroke assessment by the neurologist, dated 24 June 2010;
- A renal biopsy report by the renal physician, dated 10 March 2014;
- A haemodialysis commencement by the renal physician, dated 5 August 2014;
- An endocrinology consultation by the endocrinologist, dated 20 April 2015;
- A burns unit discharge summary by the burns surgeon, dated 14 November 2015;
- A skin biopsy and specialist consultation by the infectious diseases physician, dated 18 January 2016;
- An X-ray left elbow and orthopaedic consultation by the orthopaedic surgeon, dated 12 June 2016;
- An elbow arthroscopy operation report by the orthopaedic surgeon, dated 26 July 2016;
- A pre-anaesthetic assessment by the anaesthetist, dated 28 September 2016;
- An operation report and discharge summary (caesarean section) by the obstetrician, dated 30 September 2016;
- An outpatient health record by the medical officer, Garrison health centre, dated 14 October 2016;
- A nerve conduction study and ultrasound by the neurologist, dated 2 November 2016;
- An operation report (ulnar nerve transposition) by the hand surgeon, dated 21 November 2016;
- A repeat nerve conduction study by the neurologist, dated 13 December 2016.

## Your service

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

15 January 2003 and 30 April 2018

## Left Elbow - Ulnar Neuropathy (Worsening)

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

- *having a fracture of the bones of the affected elbow, including fracture of the medial epicondyle of the humerus, before the clinical worsening of ulnar neuropathy at the elbow*
- *having trauma to the affected elbow within the one year before the clinical worsening of ulnar neuropathy at the elbow*
- *performing repetitive and forceful activities involving flexion and extension of the affected elbow: (a) for a cumulative period of at least 90 hours, within a continuous period of three months before the clinical worsening of ulnar neuropathy at the elbow; and (b) where the repetitive and forceful activities have not ceased more than 30 days before the clinical worsening of ulnar neuropathy at the elbow*
- *having a surgical procedure under general anaesthesia, within the one month before the clinical worsening of ulnar neuropathy at the elbow*
- *having a surgical procedure to the affected elbow, including elbow arthroscopy, within the six months before the clinical worsening of ulnar neuropathy at the elbow*
- *being hospitalised, or confined to bed in a supine position, for at least two days within the two weeks before the clinical worsening of ulnar neuropathy at the elbow*
- *daily self-propulsion of a manual wheelchair: (a) for a cumulative period of at least 60 hours within a continuous period of three months before the clinical worsening of ulnar neuropathy at the elbow; and (b) where this activity has not ceased more than 30 days before the clinical worsening of ulnar neuropathy at the elbow*
- *having paraplegia at the time of the clinical worsening of ulnar neuropathy at the elbow*
- *using elbow or forearm crutches: (a) for a cumulative period of at least 60 hours within a continuous period of three months before the clinical worsening of ulnar neuropathy at the elbow; and (b) where this activity has not ceased more than 30 days before the clinical worsening of ulnar neuropathy at the elbow*
- *having an inflammatory or degenerative joint disease from the specified list of specified list of inflammatory and degenerative joint diseases, involving the affected elbow, at the time of the clinical worsening of ulnar neuropathy at the elbow*
- *having amyloidosis at the time of the clinical worsening of ulnar neuropathy at the elbow*
- *having a cerebrovascular accident with hemiplegia, excluding transient ischaemic attack or transient symptoms with infarction, before the clinical worsening of ulnar neuropathy at the elbow*
- *having an external burn to the affected arm requiring hospitalisation, within the two years before the clinical worsening of ulnar neuropathy at the elbow*
- *having an infection involving the affected ulnar nerve in the region of the elbow at the time of the clinical worsening of ulnar neuropathy at the elbow*
- *having a lesion as specified at the elbow that compresses or displaces the affected ulnar nerve at the time of the clinical worsening of ulnar neuropathy at the elbow*

- *having acromegaly before the clinical worsening of ulnar neuropathy at the elbow*
- *inability to obtain appropriate clinical management for ulnar neuropathy at the elbow*

**Diagnosis:** Ulnar Neuropathy (Worsening)

**Basis of diagnosis:** The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 10 October 2025, and is supported by a nerve conduction study and ultrasound by the neurologist, dated 2 November 2016.

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

*Statement of Principles concerning Ulnar Neuropathy at the Elbow (Balance of Probabilities) (No. 66 of 2017)*

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

I am satisfied that you have met the following factor:

- *having a fracture of the bones of the affected elbow, including fracture of the medial epicondyle of the humerus, before the clinical worsening of ulnar neuropathy at the elbow*
- *having trauma to the affected elbow within the one year before the clinical worsening of ulnar neuropathy at the elbow*
- *performing repetitive and forceful activities involving flexion and extension of the affected elbow: (a) for a cumulative period of at least 90 hours, within a continuous period of three months before the clinical worsening of ulnar neuropathy at the elbow; and (b) where the repetitive and forceful activities have not ceased more than 30 days before the clinical worsening of ulnar neuropathy at the elbow*
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- *inability to obtain appropriate clinical management for ulnar neuropathy at the elbow*

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 tingling and numbness of the left ring and little fingers and the ulnar side of the hand, worse when the elbow was bent, at night and when leaning on the elbow, with a weak grip and clumsiness with fine tools.Since the December 2016 worsening you have constant numbness in the ulnar distribution, wasting of the intrinsic hand muscles, clawing of the ring and little fingers and weak pinch on 14 October 2016.

The diagnosis was confirmed by nerve conduction studies on 2 November 2016, which showed slowing of left ulnar motor conduction across the elbow to 32 m/s compared with 54 m/s in the forearm, and a reduced ulnar sensory action potential, with normal median nerve studies. A neurologist confirmed ulnar neuropathy at the left elbow. With altered sensation and weakness in the ulnar distribution and electrodiagnostic evidence of impaired ulnar nerve function at the elbow, this meets the Statement of Principles definition.

After the condition arose, it was worsened during your service. The 2010 medial epicondyle fracture preceded the documented worsening on 5 December 2016. The fall onto the left elbow on 12 June 2016, splinted for three weeks, occurred within the one year before the worsening, from 5 December 2015 to 5 December 2016. From 5 September 2016 to 5 December 2016 you continued 15 to 20 wheelchair transfers a day and lifted equipment cases on your return to part-time duties from 7 November 2016, well over 90 hours, and transfers continued after your surgery up to the worsening. Ulnar nerve decompression and anterior transposition were performed under general anaesthesia on 21 November 2016, within the one month before the worsening. The left elbow arthroscopy of 26 July 2016 and the ulnar nerve transposition of 21 November 2016 both fall within the six months before the worsening, from 5 June 2016 to 5 December 2016. You were in hospital from 21 November 2016 to 25 November 2016 with a wound infection after the transposition, within the two weeks before the worsening. Daily

wheelchair self-propulsion of 3 to 4 hours continued from 5 September 2016 to 5 December 2016, more than 250 hours, including in the days after the surgery. Paraplegia from the T12 spinal cord injury was present at the worsening. You used forearm crutches for at least one hour a day from 5 September 2016 until your surgery on 21 November 2016, more than 60 hours, ceasing 14 days before the worsening. Post-traumatic osteoarthritis of the left elbow was present at the worsening and was seen at the transposition operation. AA amyloidosis with renal failure on haemodialysis was present at the worsening. The 2010 stroke with left hemiplegia preceded the worsening. The left forearm and elbow burn of 14 November 2015, requiring six days in a burns unit, falls within the two years before the worsening, from 5 December 2014 to 5 December 2016. Leprosy of the left ulnar nerve was still under multidrug therapy at the worsening, and the surgeon recorded a thickened, inflamed nerve at operation, with granulomatous neuritis on biopsy. After the transposition, a haematoma and fresh scar at the new site compressed the nerve, shown on ultrasound on 13 December 2016 at the level of the new conduction block. Acromegaly, diagnosed on 20 April 2015 and only partly controlled after pituitary surgery, preceded the worsening. Nerve conduction studies were not available for three weeks after you presented on 14 October 2016, and the surgery was performed while your leprous neuritis was active and your diabetes poorly controlled, leading to a wound infection, a postoperative haematoma and worsening.

This has then led to further investigations and the diagnosis of your condition of *Ulnar Neuropathy (Worsening)*. I have accepted your condition of *Ulnar Neuropathy (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 5 December 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.*