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 Neuropraxia

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 July 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 22 July 2025;
- A post-deployment health screening and tuberculin skin test by the medical officer, dated 14 March 2007;
- A trauma admission (operation and imaging reports) by Role 3 hospital, Iraq, dated 24 May 2017;
- A rheumatology consultation by the rheumatologist, dated 11 September 2017;
- An endocrinology review by the endocrinologist, dated 4 December 2017;
- A renal medicine consultation by the renal physician, dated 5 April 2018;
- A burns unit discharge summary by the plastic surgeon, dated 20 August 2018;
- A stroke admission and discharge summary by the neurologist, dated 3 October 2018;
- An emergency department record and X-ray report by the emergency physician and radiologist, dated 7 January 2019;
- An operation report by the orthopaedic surgeon, dated 18 February 2019;
- A fat pad biopsy report by the anatomical pathologist, dated 12 March 2019;
- An operation report and discharge summaries by the gynaecologist, dated 22 April 2019;
- A rehabilitation review by the rehabilitation physician, dated 30 April 2019;
- An outpatient health record by the medical officer, Garrison health centre, dated 17 May 2019;
- A nerve conduction study and ultrasound reports by the neurophysiologist and radiologist, dated 23 May 2019;

- An operation and histopathology reports by the hand surgeon and anatomical pathologist, dated 18 June 2019;
- A repeat nerve conduction study and MRI reports by the neurophysiologist and radiologist, dated 10 July 2019;
- An operation report by the hand surgeon, dated 19 November 2019.

Your service

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

5 July 2003 and 15 March 2021

Left Elbow - Ulnar Neuropraxia

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 Neuropraxia

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 22 July 2025, and is supported by a nerve conduction study and ultrasound reports by the neurophysiologist and radiologist, dated 23 May 2019.

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 numbness and tingling of the left ring and little fingers, weakness of grip and difficulty controlling your push rims, worse with the elbow bent on 17 May 2019.

The diagnosis was confirmed by nerve conduction studies on 23 May 2019, which showed focal conduction block and slowing of ulnar motor conduction to 38 m/s across the left elbow, in the presence of numbness and weakness in the ulnar distribution. This meets both limbs of the Statement of Principles definition of ulnar neuropathy at the elbow, and the pattern of conduction block with preserved distal responses is that of neuropraxia.

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

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 14 May 2019.

Left Elbow - Ulnar Neuropraxia (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 July 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 22 July 2025;
- A post-deployment health screening and tuberculin skin test by the medical officer, dated 14 March 2007;
- A trauma admission (operation and imaging reports) by Role 3 hospital, Iraq, dated 24 May 2017;
- A rheumatology consultation by the rheumatologist, dated 11 September 2017;
- An endocrinology review by the endocrinologist, dated 4 December 2017;
- A renal medicine consultation by the renal physician, dated 5 April 2018;
- A burns unit discharge summary by the plastic surgeon, dated 20 August 2018;
- A stroke admission and discharge summary by the neurologist, dated 3 October 2018;
- An emergency department record and X-ray report by the emergency physician and radiologist, dated 7 January 2019;
- An operation report by the orthopaedic surgeon, dated 18 February 2019;
- A fat pad biopsy report by the anatomical pathologist, dated 12 March 2019;
- An operation report and discharge summaries by the gynaecologist, dated 22 April 2019;
- A rehabilitation review by the rehabilitation physician, dated 30 April 2019;
- An outpatient health record by the medical officer, Garrison health centre, dated 17 May 2019;
- A nerve conduction study and ultrasound reports by the neurophysiologist and radiologist, dated 23 May 2019;
- An operation and histopathology reports by the hand surgeon and anatomical pathologist, dated 18 June 2019;
- A repeat nerve conduction study and MRI reports by the neurophysiologist and radiologist, dated 10 July 2019;
- An operation report by the hand surgeon, dated 19 November 2019.

Your service

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

5 July 2003 and 15 March 2021

Left Elbow - Ulnar Neuropraxia (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 Neuropraxia (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 22 July 2025, and is supported by a nerve conduction study and ultrasound reports by the neurophysiologist and radiologist, dated 23 May 2019.

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*
- *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*

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 numbness and tingling of the left ring and little fingers, weakness of grip and difficulty controlling your push rims, worse with the elbow bent on 17 May 2019.

The diagnosis was confirmed by nerve conduction studies on 23 May 2019, which showed focal conduction block and slowing of ulnar motor conduction to 38 m/s across the left elbow, in the presence of numbness and weakness in the ulnar distribution. This meets both limbs of the Statement of Principles definition of ulnar neuropathy at the elbow, and the pattern of conduction block with preserved distal responses is that of neuropraxia.

After the condition arose, it was worsened during your service. The left distal humeral fracture of 24 May 2017 preceded the worsening on 28 June 2019. The elbow trauma of 7 January 2019 was within the 1 year before the worsening, from 28 June 2018 to 28 June 2019. Daily transfers and handcycle training continued throughout the 3 months before the worsening, from 28 March 2019 to 28 June 2019, apart from short admissions, totalling more than 90 hours and continuing to the worsening. Surgical biopsy of the left elbow mass under general anaesthesia on 18 June 2019 was within the 1 month before the worsening, from 28 May 2019 to 28 June 2019. The surgical biopsy of 18 June 2019 was surgery to the affected elbow within the 6 months before the worsening, as was the arthroscopy of 18 February 2019. You were admitted from 18 to 21 June

2019, within the 2 weeks before the worsening, from 14 June 2019 to 28 June 2019. Daily self-propulsion of your manual wheelchair continued for more than 60 hours within the 3 months before the worsening and up to it. Incomplete paraplegia was present at the worsening. Forearm crutch walking continued for more than 60 hours within the 3 months before the worsening and into June 2019. Lupus arthritis and post-traumatic osteoarthritis of the left elbow persisted at the worsening. AA amyloidosis persisted at the worsening. The stroke with right hemiplegia of 3 October 2018 preceded the worsening. The hospitalised scald to the left forearm and elbow region of 20 August 2018 was within the 2 years before the worsening. Tuberculosis involving the left ulnar nerve was active and untreated at the worsening, confirmed on culture of the biopsy taken on 18 June 2019. The tuberculoma persisted and enlarged to 19 mm, encasing the nerve, at the worsening, as shown on MRI on 10 July 2019. Acromegaly preceded the worsening. Antituberculous treatment was delayed until 6 August 2019 by slow culture results and delayed specialist review, and the latent infection found in 2007 had never been fully treated.

This has then led to further investigations and the diagnosis of your condition of *Ulnar Neuropraxia (Worsening)*. I have accepted your condition of *Ulnar Neuropraxia (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 28 June 2019.

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.