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 Shoulder - Tendinopathy

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 2 September 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 2 September 2025;
- A field hospital record and X-ray by the east timor, dated 14 November 1999;
- An operation report by the orthopaedic surgeon, dated 3 May 2001;
- A nerve conduction study and neurology report by the neurologist, Afghanistan, dated 22 September 2008;
- A trauma admission and CT reports by Role 3 hospital, Afghanistan, dated 23 July 2011;
- A renal medicine record by the nephrologist, dated 26 July 2011;
- A specialist consultation by the rheumatologist, dated 18 March 2013;
- An outpatient health record and pathology by the medical officer, dated 10 June 2014;
- A histopathology and nephrology review by the pathologist and nephrologist, dated 9 August 2016;
- A rehabilitation review by the rehabilitation physician, dated 7 February 2017;
- An outpatient health record and aspirate microscopy and culture by the medical officer, dated 6 March 2017;
- An MRI left shoulder by the radiologist, dated 20 March 2017;
- An operation report by the orthopaedic surgeon, dated 3 April 2017;
- An MRI left shoulder and orthopaedic review by the radiologist and orthopaedic surgeon, dated 14 November 2017.

Your service

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

27 January 1997 and 22 June 2019

Left Shoulder - Tendinopathy

You have stated that your condition was caused by:

- *having an injury to the affected shoulder within the 30 days before the clinical onset of rotator cuff syndrome*
- *undergoing a surgical procedure involving the affected shoulder joint before the clinical onset of rotator cuff syndrome*
- *performing any combination of: (a) repetitive or sustained activities of the affected shoulder when the shoulder on the affected side is abducted or flexed by at least 60 degrees; or (b) forceful activities with the affected upper limb; for at least 160 hours within a period of 210 consecutive days before the clinical onset of rotator cuff syndrome, and where the repetitive or sustained or forceful activities have not ceased more than 30 days before the clinical onset of rotator cuff syndrome*
- *performing repetitive or sustained activities of the affected shoulder when the shoulder on the affected side is abducted or flexed by at least 60 degrees for at least 4,000 hours within the 10 years before the clinical onset of rotator cuff syndrome*
- *lifting or carrying loads of at least 20 kilograms using the upper limb of the affected side for at least 400 hours within the 10 years before the clinical onset of rotator cuff syndrome*
- *having dialysis-related amyloidosis before the clinical onset of rotator cuff syndrome*
- *regularly using the upper limbs for weight-bearing for a continuous period of at least the 1 year before the clinical onset of rotator cuff syndrome*
- *having anatomical narrowing of the subacromial space on the affected side at the time of the clinical onset of rotator cuff syndrome*
- *having joint instability of the affected shoulder, or dislocation or subluxation of the affected shoulder joint before the clinical onset of rotator cuff syndrome*
- *having an infection of the subacromial bursa or subdeltoid bursa of the affected shoulder at the time of the clinical onset of rotator cuff syndrome*
- *having an autoimmune disease from the specified list of autoimmune diseases, involving the shoulder joint or associated bursae of the affected side, before the clinical onset of rotator cuff syndrome*
- *having gout involving the affected shoulder at the time of the clinical onset of rotator cuff syndrome*
- *having diabetes mellitus before the clinical onset of rotator cuff syndrome*
- *having dyslipidaemia before the clinical onset of rotator cuff syndrome*

- *taking a glucocorticoid drug as specified before the clinical onset of rotator cuff syndrome*
- *taking a fluoroquinolone antibiotic within the 60 days before the clinical onset of rotator cuff syndrome*

Diagnosis: Tendinopathy

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 2 September 2025, and is supported by an MRI left shoulder by the radiologist, dated 20 March 2017.

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

Statement of Principles concerning Rotator Cuff Syndrome (Balance of Probabilities) (No. 110 of 2022)

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

I am satisfied that you have met the following factor:

- *having an injury to the affected shoulder within the 30 days before the clinical onset of rotator cuff syndrome*
- *undergoing a surgical procedure involving the affected shoulder joint before the clinical onset of rotator cuff syndrome*
- *performing any combination of: (a) repetitive or sustained activities of the affected shoulder when the shoulder on the affected side is abducted or flexed by at least 60 degrees; or (b) forceful activities with the affected upper limb; for at least 160 hours within a period of 210 consecutive days before the clinical onset of rotator cuff syndrome, and where the repetitive or sustained or forceful activities have not ceased more than 30 days before the clinical onset of rotator cuff syndrome*
- *performing repetitive or sustained activities of the affected shoulder when the shoulder on the affected side is abducted or flexed by at least 60 degrees for at least 4,000 hours within the 10 years before the clinical onset of rotator cuff syndrome*
- *lifting or carrying loads of at least 20 kilograms using the upper limb of the affected side for at least 400 hours within the 10 years before the clinical onset of rotator cuff syndrome*
- *having dialysis-related amyloidosis before the clinical onset of rotator cuff syndrome*
- *regularly using the upper limbs for weight-bearing for a continuous period of at least the 1 year before the clinical onset of rotator cuff syndrome*
- *having anatomical narrowing of the subacromial space on the affected side at the time of the clinical onset of rotator cuff syndrome*
- *having joint instability of the affected shoulder, or dislocation or subluxation of the affected shoulder joint before the clinical onset of rotator cuff syndrome*
- *having an infection of the subacromial bursa or subdeltoid bursa of the affected shoulder at the time of the clinical onset of rotator cuff syndrome*

- *having an autoimmune disease from the specified list of autoimmune diseases, involving the shoulder joint or associated bursae of the affected side, before the clinical onset of rotator cuff syndrome*
- *having gout involving the affected shoulder at the time of the clinical onset of rotator cuff syndrome*
- *having diabetes mellitus before the clinical onset of rotator cuff syndrome*
- *having dyslipidaemia before the clinical onset of rotator cuff syndrome*
- *taking a glucocorticoid drug as specified before the clinical onset of rotator cuff syndrome*
- *taking a fluoroquinolone antibiotic within the 60 days before the clinical onset of rotator cuff syndrome*

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 constant aching pain in the outer left shoulder, sharp pain on lifting the arm to the side and overhead, night pain preventing you from lying on the left side, weakness when pushing up on crutches and transferring, and fever from the infected bursa.After the November 2017 worsening you lost the ability to lift the left arm above shoulder height against resistance on 6 March 2017.

The diagnosis was made by an orthopaedic surgeon on the basis of the clinical findings of 6 March 2017, a painful arc from 70 to 120 degrees, positive impingement signs and weak resisted abduction, and MRI of 20 March 2017, which showed supraspinatus and infraspinatus tendinopathy with a 9 millimetre partial-thickness supraspinatus tear and subacromial bursitis. This meets the Statement of Principles definition of rotator cuff syndrome, with persistent pain and tenderness in the rotator cuff region and pain on active movement.

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

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 6 March 2017.

Left Shoulder - Tendinopathy (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 2 September 2025;
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- An MRI left shoulder by the radiologist, dated 20 March 2017;
- An operation report by the orthopaedic surgeon, dated 3 April 2017;
- An MRI left shoulder and orthopaedic review by the radiologist and orthopaedic surgeon, dated 14 November 2017.

Your service

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

27 January 1997 and 22 June 2019

Left Shoulder - Tendinopathy (Worsening)

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

- *having an injury to the affected shoulder within the 30 days before the clinical worsening of rotator cuff syndrome*
- *undergoing a surgical procedure involving the affected shoulder joint before the clinical worsening of rotator cuff syndrome*
- *performing any combination of: (a) repetitive or sustained activities of the affected shoulder when the shoulder on the affected side is abducted or flexed by at least 60 degrees; or (b) forceful activities with the affected upper limb; for at least 160 hours within a period of 210 consecutive days before the clinical worsening of rotator cuff syndrome, and where the repetitive or sustained or forceful activities have not ceased more than 30 days before the clinical worsening of rotator cuff syndrome*
- *performing repetitive or sustained activities of the affected shoulder when the shoulder on the affected side is abducted or flexed by at least 60 degrees for at least 4,000 hours within the 10 years before the clinical worsening of rotator cuff syndrome*
- *lifting or carrying loads of at least 20 kilograms using the upper limb of the affected side for at least 400 hours within the 10 years before the clinical worsening of rotator cuff syndrome*
- *having dialysis-related amyloidosis before the clinical worsening of rotator cuff syndrome*
- *regularly using the upper limbs for weight-bearing for a continuous period of at least the 1 year before the clinical worsening of rotator cuff syndrome*
- *having anatomical narrowing of the subacromial space on the affected side at the time of the clinical worsening of rotator cuff syndrome*
- *having joint instability of the affected shoulder, or dislocation or subluxation of the affected shoulder joint before the clinical worsening of rotator cuff syndrome*
- *having an infection of the subacromial bursa or subdeltoid bursa of the affected shoulder at the time of the clinical worsening of rotator cuff syndrome*
- *having an autoimmune disease from the specified list of autoimmune diseases, involving the shoulder joint or associated bursae of the affected side, before the clinical worsening of rotator cuff syndrome*
- *having gout involving the affected shoulder at the time of the clinical worsening of rotator cuff syndrome*
- *having diabetes mellitus before the clinical worsening of rotator cuff syndrome*
- *having dyslipidaemia before the clinical worsening of rotator cuff syndrome*
- *taking a glucocorticoid drug as specified before the clinical worsening of rotator cuff syndrome*
- *taking a fluoroquinolone antibiotic within the 60 days before the clinical worsening of rotator cuff syndrome*
- *inability to obtain appropriate clinical management for rotator cuff syndrome*

Diagnosis: Tendinopathy (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 2 September 2025, and is supported by an MRI left shoulder by the radiologist, dated 20 March 2017.

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

Statement of Principles concerning Rotator Cuff Syndrome (Balance of Probabilities) (No. 110 of 2022)

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

I am satisfied that you have met the following factor:

- *having an injury to the affected shoulder within the 30 days before the clinical worsening of rotator cuff syndrome*
- *undergoing a surgical procedure involving the affected shoulder joint before the clinical worsening of rotator cuff syndrome*
- *performing any combination of: (a) repetitive or sustained activities of the affected shoulder when the shoulder on the affected side is abducted or flexed by at least 60 degrees; or (b) forceful activities with the affected upper limb; for at least 160 hours within a period of 210 consecutive days before the clinical worsening of rotator cuff syndrome, and where the repetitive or sustained or forceful activities have not ceased more than 30 days before the clinical worsening of rotator cuff syndrome*
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- *having gout involving the affected shoulder at the time of the clinical worsening of rotator cuff syndrome*
- *having diabetes mellitus before the clinical worsening of rotator cuff syndrome*
- *having dyslipidaemia before the clinical worsening of rotator cuff syndrome*
- *taking a glucocorticoid drug as specified before the clinical worsening of rotator cuff syndrome*
- *taking a fluoroquinolone antibiotic within the 60 days before the clinical worsening of rotator cuff syndrome*
- *inability to obtain appropriate clinical management for rotator cuff syndrome*

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 constant aching pain in the outer left shoulder, sharp pain on lifting the arm to the side and overhead, night pain preventing you from lying on the left side, weakness when pushing up on crutches and transferring, and fever from the infected bursa.After the November 2017 worsening you lost the ability to lift the left arm above shoulder height against resistance on 6 March 2017.

The diagnosis was made by an orthopaedic surgeon on the basis of the clinical findings of 6 March 2017, a painful arc from 70 to 120 degrees, positive impingement signs and weak resisted abduction, and MRI of 20 March 2017, which showed supraspinatus and infraspinatus tendinopathy with a 9 millimetre partial-thickness supraspinatus tear and subacromial bursitis. This meets the Statement of Principles definition of rotator cuff syndrome, with persistent pain and tenderness in the rotator cuff region and pain on active movement.

After the condition arose, it was worsened during your service. On 25 October 2017 you fell again while transferring from your wheelchair and landed on the left shoulder, with pain, tenderness and reduced movement recorded that day and persisting beyond 7 days. You underwent an arthroscopic Bankart repair of the left shoulder on 3 May 2001 for recurrent instability after the dislocation of 14 November 1999. In the 210 days before the worsening, from 18 April 2017 to 14 November 2017, you used crutches and your wheelchair every day and resumed swimming 6 to 8 hours a week from June 2017, forceful and overhead activities of the left upper limb totalling well over 160 hours. From March 2007 to July 2011 your construction and field troop duties involved about 18 to 25 hours a week of overhead work, fixing roof sheeting, purlins and ceiling frames and drilling above head height, recorded in your trade logbook, about 3,000 hours. From March 2007 to July 2011 you lifted and carried sandbags, formwork, steel sections and ammunition boxes of 20 to 40 kilograms with both arms for about 6 hours a week on construction tasks and deployments, a total of more than 1,000 hours. You have been on haemodialysis three times a week since 26 July 2011 for kidney failure after rhabdomyolysis from your blast injuries. Since the blast of 23 July 2011 you have walked with elbow crutches and propelled and transferred from a wheelchair every day, bearing your body weight of about 95 kilograms through both upper limbs, because stump breakdown repeatedly prevented use of your prosthesis. The fracture of the left greater tuberosity sustained in the blast

of 23 July 2011 healed with 6 millimetres of superior displacement, and MRI of 20 March 2017 showed the malunited tuberosity narrowing the subacromial space to 5 millimetres. You dislocated the left shoulder on 14 November 1999 and had two further subluxations in 2000 before stabilisation surgery in 2001, so you had dislocation, subluxation and instability of the affected shoulder long before onset. Recurrent subacromial bursal effusion was aspirated on 14 November 2017 and again grew Staphylococcus aureus, a recurrence of the bursal infection at the time of the worsening. Seropositive rheumatoid arthritis was diagnosed on 18 March 2013, with synovitis of the left glenohumeral joint on ultrasound and glenohumeral synovitis on MRI of 20 March 2017. Urate crystals were again present in the bursal aspirate of 14 November 2017, so gout involved the left shoulder at the time of the worsening. Type 2 diabetes was diagnosed in June 2014 with an HbA1c of 7.9 per cent, after more than a year of prednisolone for rheumatoid arthritis and during prolonged immobility after your amputation, and was treated with insulin. A medical practitioner diagnosed dyslipidaemia in 2013 with an LDL cholesterol of 4.6 mmol/L and a triglyceride level of 2.8 mmol/L, and you have taken atorvastatin regularly since. You have taken prednisolone 10 mg daily since 18 March 2013 for rheumatoid arthritis, 1.8 grams in each 6 months and more than 14 grams in total, so you took at least 0.5 grams over 6 months within the 3 years before the worsening, at least 3 grams within the 5 years before the worsening the worsening, and more than 10 grams in total. Moxifloxacin 400 mg daily was prescribed from 6 October 2017 to 15 October 2017 for community-acquired pneumonia, within the 60 days before the worsening, from 15 September 2017 to 14 November 2017. After onset, orthopaedic review and a surgical opinion on cuff repair were delayed seven months by waiting lists, and because you depended on crutches and a wheelchair you could not rest or offload the shoulder.

This has then led to further investigations and the diagnosis of your condition of *Tendinopathy (Worsening)*. I have accepted your condition of *Tendinopathy (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 14 November 2017.

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.