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.

Respiratory - Upper Respiratory Tract Infection

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 27 October 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 27 October 2025;
- An enlistment medical examination by the medical officer, dated 17 June 1998;
- A treatment record by the medical officer, Middle East Area of Operations, dated 6 February 2006;
- A treatment record and nasal swab report by the flight surgeon, Middle East Area of Operations, dated 3 March 2006;
- An annual aircrew medical examination by the flight surgeon, dated 21 August 2007;
- A treatment record by the medic, Middle East Area of Operations, dated 18 May 2015;
- A treatment record and chest X-ray report by the flight surgeon and radiologist, Middle East Area of Operations, dated 16 June 2015;
- A specialist consultation (nasendoscopy and CT sinus report) by the ear, nose and throat surgeon and Radiologist, dated 4 February 2016.

Your service

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

17 June 1998 and 30 September 2020

Respiratory - Upper Respiratory Tract Infection

You have stated that your condition was caused by:

- *being in close contact with a person who has a viral upper respiratory tract infection within the 7 days before the clinical onset of upper respiratory tract infection*
- *living or working in crowded communal accommodation, with at least 4 people sharing a room or tent, for at least 7 days within the 14 days before the clinical onset of upper respiratory tract infection*
- *having sleep deprivation or circadian disruption, with an average of less than 5 hours of sleep per day, for at least 3 days within the 7 days before the clinical onset of upper respiratory tract infection*
- *experiencing a severe psychological stressor within the one month before the clinical onset of upper respiratory tract infection*
- *being treated with a systemic corticosteroid within the 30 days before the clinical onset of upper respiratory tract infection*
- *being exposed to low-humidity aircraft cabin air for at least 6 hours within the 72 hours before the clinical onset of upper respiratory tract infection*
- *inhaling airborne dusts, smoke from fires, or fumes or vapours from fuel within the 48 hours before the clinical onset of upper respiratory tract infection*

Diagnosis: Upper Respiratory Tract Infection

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 27 October 2025, and is supported by a treatment record and nasal swab report by the flight surgeon, Middle East Area of Operations, dated 3 March 2006.

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:

- *being in close contact with a person who has a viral upper respiratory tract infection within the 7 days before the clinical onset of upper respiratory tract infection*
- *living or working in crowded communal accommodation, with at least 4 people sharing a room or tent, for at least 7 days within the 14 days before the clinical onset of upper respiratory tract infection*
- *having sleep deprivation or circadian disruption, with an average of less than 5 hours of sleep per day, for at least 3 days within the 7 days before the clinical onset of upper respiratory tract infection*
- *experiencing a severe psychological stressor within the one month before the clinical onset of upper respiratory tract infection*

- *being treated with a systemic corticosteroid within the 30 days before the clinical onset of upper respiratory tract infection*
- *being exposed to low-humidity aircraft cabin air for at least 6 hours within the 72 hours before the clinical onset of upper respiratory tract infection*
- *inhaling airborne dusts, smoke from fires, or fumes or vapours from fuel within the 48 hours before the clinical onset of upper respiratory tract infection*

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 a sore throat, sneezing, watery nasal discharge, nasal blockage, hoarseness, a dry cough and a low-grade fever with malaise, lasting about 12 days on 3 March 2006.

The diagnosis was made clinically by the flight surgeon on 3 March 2006 from the typical sore throat, sneezing, rhinorrhoea, nasal blockage, hoarseness, cough and fever, and confirmed by a nasal swab positive for adenovirus and negative for influenza. The recurrent pattern of about four infections a year is documented at your aircrew medical of 21 August 2007 and in your flying medical records to 2014.

This has then led to further investigations and the diagnosis of your condition of *Upper Respiratory Tract Infection*. I have accepted your condition of *Upper Respiratory Tract Infection*.

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

I have therefore accepted that this condition is related to your service with effect from 3 March 2006.

Respiratory - Upper Respiratory Tract Infection (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 27 October 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 27 October 2025;
- An enlistment medical examination by the medical officer, dated 17 June 1998;
- A treatment record by the medical officer, Middle East Area of Operations, dated 6 February 2006;
- A treatment record and nasal swab report by the flight surgeon, Middle East Area of Operations, dated 3 March 2006;
- An annual aircrew medical examination by the flight surgeon, dated 21 August 2007;
- A treatment record by the medic, Middle East Area of Operations, dated 18 May 2015;
- A treatment record and chest X-ray report by the flight surgeon and radiologist, Middle East Area of Operations, dated 16 June 2015;
- A specialist consultation (nasendoscopy and CT sinus report) by the ear, nose and throat surgeon and Radiologist, dated 4 February 2016.

Your service

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

17 June 1998 and 30 September 2020

Respiratory - Upper Respiratory Tract Infection (Worsening)

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

- *being in close contact with persons who have viral upper respiratory tract infections, in crowded communal accommodation, within the 7 days before the clinical worsening of upper respiratory tract infection*
- *having sleep deprivation or circadian disruption, with an average of less than 5 hours of sleep per day, for at least 3 days within the 7 days before the clinical worsening of upper respiratory tract infection*

- *inhaling airborne dusts, smoke from fires, or fumes or vapours from fuel within the 48 hours before the clinical worsening of upper respiratory tract infection*
- *inability to obtain appropriate clinical management for upper respiratory tract infection*

Diagnosis: Upper Respiratory Tract Infection (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 27 October 2025, and is supported by a treatment record and nasal swab report by the flight surgeon, Middle East Area of Operations, dated 3 March 2006.

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:

- *being in close contact with persons who have viral upper respiratory tract infections, in crowded communal accommodation, within the 7 days before the clinical worsening of upper respiratory tract infection*
- *having sleep deprivation or circadian disruption, with an average of less than 5 hours of sleep per day, for at least 3 days within the 7 days before the clinical worsening of upper respiratory tract infection*
- *inhaling airborne dusts, smoke from fires, or fumes or vapours from fuel within the 48 hours before the clinical worsening of upper respiratory tract infection*
- *inability to obtain appropriate clinical management for upper respiratory tract infection*

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 a sore throat, sneezing, watery nasal discharge, nasal blockage, hoarseness, a dry cough and a low-grade fever with malaise, lasting about 12 days on 3 March 2006.

The diagnosis was made clinically by the flight surgeon on 3 March 2006 from the typical sore throat, sneezing, rhinorrhoea, nasal blockage, hoarseness, cough and fever, and confirmed by a nasal swab positive for adenovirus and negative for influenza. The recurrent pattern of about four infections a year is documented at your aircrew medical of 21 August 2007 and in your flying medical records to 2014.

After the condition arose, it was worsened during your service. On warlike service in the Middle East in May 2015 you lived in an eight-person crew room, and in the week before 18 May 2015 four of your crew had colds. From 11 to 17 May 2015 you flew night sorties on warlike service

and slept about four hours a day, within the 7 days before the worsening on 18 May 2015, as your flying log and fatigue reports show. On 17 May 2015 a dust storm covered the air base while you were loading aircraft, and you worked in jet fuel vapour during refuelling, within the 48 hours before the worsening on 18 May 2015. On 19 May 2015, with an active infection, you were required to fly a return sector because no replacement loadmaster was available, against usual aviation medicine practice of grounding, and suffered severe ear barotrauma.

This has then led to further investigations and the diagnosis of your condition of *Upper Respiratory Tract Infection (Worsening)*. I have accepted your condition of *Upper Respiratory Tract Infection (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 18 May 2015.

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