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.

Right Elbow - Common Flexor Origin Tendinosis

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 21 May 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 21 May 2025;
- A periodic health examination by the medical officer, RAAF health centre, dated 18 February 2008;
- A deployed health record and stool culture by the detachment medical officer, dated 1 March 2009;
- A deployed health record by the detachment medical officer, dated 11 March 2009;
- A deployed health record by the detachment medical officer, dated 17 March 2009;
- An ultrasound right elbow by the radiologist, coalition role 3 hospital, dated 8 April 2009;
- A rheumatology consultation and MRI sacroiliac joints by the rheumatologist, dated 6 September 2011;
- A deployed health record by the detachment medical officer, dated 12 August 2013;
- An MRI right elbow and orthopaedic consultation by the orthopaedic surgeon, dated 22 October 2013.

Your service

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

12 July 1999 and 3 May 2018

Right Elbow - Common Flexor Origin Tendinosis

You have stated that your condition was caused by:

- *performing forceful activities with the hand or forearm on the affected side, in combination with: repetitive activities with the hand or forearm on the affected side; for at least 1 hour per day, on more days than not, over a period of at least the 4 weeks before the clinical onset of epicondylitis*
- *performing forceful activities with the hand or forearm on the affected side, in combination with: sustained activities with the hand or forearm on the affected side; for at least 1 hour per day, on more days than not, over a period of at least the 4 weeks before the clinical onset of epicondylitis*
- *using a hand-held computer mouse on the affected side for at least 20 hours per week in the 6 months before the clinical onset of epicondylitis*
- *having a sudden alteration of loading pattern as specified for a continuous period of at least 1 hour, within the 3 days before the clinical onset of epicondylitis*
- *taking a fluoroquinolone antibiotic within the 14 days before the clinical onset of epicondylitis*
- *having spondyloarthritis at the time of the clinical onset of epicondylitis*

Diagnosis: Common Flexor Origin Tendinosis

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 21 May 2025, and is supported by an ultrasound right elbow by the radiologist, coalition role 3 hospital, dated 8 April 2009.

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

Statement of Principles concerning Epicondylitis (Reasonable Hypothesis) (No. 5 of 2023)

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

I am satisfied that you have met the following factor:

- *performing forceful activities with the hand or forearm on the affected side, in combination with: repetitive activities with the hand or forearm on the affected side; for at least 1 hour per day, on more days than not, over a period of at least the 4 weeks before the clinical onset of epicondylitis*
- *performing forceful activities with the hand or forearm on the affected side, in combination with: sustained activities with the hand or forearm on the affected side; for at least 1 hour per day, on more days than not, over a period of at least the 4 weeks before the clinical onset of epicondylitis*
- *using a hand-held computer mouse on the affected side for at least 20 hours per week in the 6 months before the clinical onset of epicondylitis*

- *having a sudden alteration of loading pattern as specified for a continuous period of at least 1 hour, within the 3 days before the clinical onset of epicondylitis*
- *taking a fluoroquinolone antibiotic within the 14 days before the clinical onset of epicondylitis*
- *having spondyloarthritis at the time of the clinical onset of epicondylitis*

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 aching and sharp pain over the inner side of the right elbow, worse with gripping, riveting, lifting tool boxes and turning tools, with tenderness over the medial epicondyle on 17 March 2009.

The diagnosis is based on the typical history of medial elbow pain aggravated by gripping and forearm use, with tenderness over the medial epicondyle and common flexor origin and pain on resisted wrist flexion and pronation, recorded by the medical officer on 17 March 2009, with normal ulnar nerve function. This meets the Statement of Principles definition of epicondylitis as a clinically symptomatic inflammatory or degenerative disorder of the tendons attaching to the medial epicondyle.

This has then led to further investigations and the diagnosis of your condition of *Common Flexor Origin Tendinosis*. I have accepted your condition of *Common Flexor Origin Tendinosis*.

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 wartime service.

I have therefore accepted that this condition is related to your service with effect from 16 March 2009.

Right Elbow - Common Flexor Origin Tendinosis (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 21 May 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 21 May 2025;
- A periodic health examination by the medical officer, RAAF health centre, dated 18 February 2008;
- A deployed health record and stool culture by the detachment medical officer, dated 1 March 2009;
- A deployed health record by the detachment medical officer, dated 11 March 2009;
- A deployed health record by the detachment medical officer, dated 17 March 2009;
- An ultrasound right elbow by the radiologist, coalition role 3 hospital, dated 8 April 2009;
- A rheumatology consultation and MRI sacroiliac joints by the rheumatologist, dated 6 September 2011;
- A deployed health record by the detachment medical officer, dated 12 August 2013;
- An MRI right elbow and orthopaedic consultation by the orthopaedic surgeon, dated 22 October 2013.

Your service

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

12 July 1999 and 3 May 2018

Right Elbow - Common Flexor Origin Tendinosis (Worsening)

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

- *performing forceful activities with the hand or forearm on the affected side, in combination with: repetitive activities with the hand or forearm on the affected side; for at least 1 hour per day, on more days than not, over a period of at least the 4 weeks before the clinical worsening of epicondylitis*

- *performing forceful activities with the hand or forearm on the affected side, in combination with: sustained activities with the hand or forearm on the affected side; for at least 1 hour per day, on more days than not, over a period of at least the 4 weeks before the clinical worsening of epicondylitis*
- *using a hand-held computer mouse on the affected side for at least 20 hours per week in the 6 months before the clinical worsening of epicondylitis*
- *having a sudden alteration of loading pattern as specified for a continuous period of at least 1 hour, within the 3 days before the clinical worsening of epicondylitis*
- *taking a fluoroquinolone antibiotic within the 14 days before the clinical worsening of epicondylitis*
- *having spondyloarthritis at the time of the clinical worsening of epicondylitis*
- *inability to obtain appropriate clinical management for epicondylitis*

Diagnosis: Common Flexor Origin Tendinosis (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 21 May 2025, and is supported by an ultrasound right elbow by the radiologist, coalition role 3 hospital, dated 8 April 2009.

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

Statement of Principles concerning Epicondylitis (Reasonable Hypothesis) (No. 5 of 2023)

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

I am satisfied that you have met the following factor:

- *performing forceful activities with the hand or forearm on the affected side, in combination with: repetitive activities with the hand or forearm on the affected side; for at least 1 hour per day, on more days than not, over a period of at least the 4 weeks before the clinical worsening of epicondylitis*
- *performing forceful activities with the hand or forearm on the affected side, in combination with: sustained activities with the hand or forearm on the affected side; for at least 1 hour per day, on more days than not, over a period of at least the 4 weeks before the clinical worsening of epicondylitis*
- *using a hand-held computer mouse on the affected side for at least 20 hours per week in the 6 months before the clinical worsening of epicondylitis*
- *having a sudden alteration of loading pattern as specified for a continuous period of at least 1 hour, within the 3 days before the clinical worsening of epicondylitis*
- *taking a fluoroquinolone antibiotic within the 14 days before the clinical worsening of epicondylitis*
- *having spondyloarthritis at the time of the clinical worsening of epicondylitis*

- *inability to obtain appropriate clinical management for epicondylitis*

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 aching and sharp pain over the inner side of the right elbow, worse with gripping, riveting, lifting tool boxes and turning tools, with tenderness over the medial epicondyle on 17 March 2009.

The diagnosis is based on the typical history of medial elbow pain aggravated by gripping and forearm use, with tenderness over the medial epicondyle and common flexor origin and pain on resisted wrist flexion and pronation, recorded by the medical officer on 17 March 2009, with normal ulnar nerve function. This meets the Statement of Principles definition of epicondylitis as a clinically symptomatic inflammatory or degenerative disorder of the tendons attaching to the medial epicondyle.

After the condition arose, it was worsened during your service. On warlike service in Afghanistan, from 15 July 2013 to 12 August 2013, you riveted and drilled with your right hand for two to four hours a day on six days a week, repairing operational aircraft. In the same 4 weeks of warlike service you held bucking bars and drills with a sustained forceful grip for more than an hour on most days. From 12 February 2013 to 12 August 2013, on warlike service in Afghanistan, you ran the detachment's maintenance planning system with a right-hand mouse for more than 20 hours a week. On 10 August 2013, after a rocket attack on the air base, you spent four hours continuously removing and refitting damaged panels with heavy power tools and carrying panels of over 10 kilograms, more than doubling your usual loading at above 5 METs, two days before the worsening. Ciprofloxacin was prescribed by the deployed medical officer from 31 July to 6 August 2013 for a urinary tract infection contracted on warlike service, within the 14 days before the worsening on 12 August 2013. Undifferentiated spondyloarthropathy, which evolved from the reactive arthritis that followed the 2009 infection on warlike service, was active at the worsening on 12 August 2013. On warlike service in Afghanistan from 12 August to 30 September 2013 no imaging, physiotherapy or specialist review was available and operational demands kept you on full duties, so the worsening tendinosis went untreated for seven weeks and progressed to a partial tear.

This has then led to further investigations and the diagnosis of your condition of *Common Flexor Origin Tendinosis (Worsening)*. I have accepted your condition of *Common Flexor Origin Tendinosis (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 wartime service.

I have therefore accepted that the worsening of this condition is related to your service with effect from 12 August 2013.

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.