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.

Upper Respiratory Tract Infections - Recurrent

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 October 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 2 October 2025;
- A ship's medical record (nasal fracture) by the ship's medical officer, dated 11 August 1996;
- An annual medical examination and allergy testing by the medical officer, dated 21 October 1997;
- A ship's medical record by the ship's medical officer, Bougainville, dated 14 March 1998;
- A ship's medical record and pathology by the ship's medical officer, dated 20 March 1998;
- A medical review and ENT referral by the medical officer, dated 5 March 1999;
- A ship's medical record by the ship's medical officer, Middle East, dated 10 September 2007;
- An ENT consultation and CT paranasal sinuses by the ENT surgeon, dated 14 February 2008.

Your service

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

20 January 1995 and 31 July 2012

Upper Respiratory Tract Infections - Recurrent

You have stated that your condition was caused by:

- *living or working in crowded communal accommodation, with at least 4 people sharing a sleeping space, for a cumulative total of at least 3 months within the one year before the clinical onset of recurrent upper respiratory tract infections*
- *being in close contact with persons who have acute upper respiratory tract infections on at least 3 separate occasions within the one year before the clinical onset of recurrent upper respiratory tract infections*
- *having sleep deprivation or circadian disruption, with an average of less than 6 hours of sleep in each 24 hours, for at least one month within the 3 months before the clinical onset of recurrent upper respiratory tract infections*
- *smoking at least 10 cigarettes per day for at least the one year before the clinical onset of recurrent upper respiratory tract infections*
- *being exposed to second-hand tobacco smoke in an enclosed space for at least 2 hours per day on more days than not for at least the 6 months before the clinical onset of recurrent upper respiratory tract infections*
- *having nasal obstruction from a deviated nasal septum or allergic rhinitis at the time of the clinical onset of recurrent upper respiratory tract infections*
- *having vitamin D deficiency, with a serum 25-hydroxyvitamin D level below 50 nanomoles per litre, at the time of the clinical onset of recurrent upper respiratory tract infections*
- *experiencing a severe or prolonged psychological stressor within the 3 months before the clinical onset of recurrent upper respiratory tract infections*
- *being exposed to air-conditioned or recirculated air with a relative humidity below 30 per cent for at least 8 hours per day for at least the 3 months before the clinical onset of recurrent upper respiratory tract infections*
- *consuming an average of at least 60 grams of alcohol per day for at least the 6 months before the clinical onset of recurrent upper respiratory tract infections*
- *inhaling respiratory irritants, including paint and solvent fumes, solder fumes or diesel exhaust, for at least 4 hours per day on at least 3 days per week for at least the 3 months before the clinical onset of recurrent upper respiratory tract infections*

Diagnosis: Recurrent

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 2 October 2025, and is supported by a medical review and ENT referral by the medical officer, dated 5 March 1999.

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:

- *living or working in crowded communal accommodation, with at least 4 people sharing a sleeping space, for a cumulative total of at least 3 months within the one year before the clinical onset of recurrent upper respiratory tract infections*
- *being in close contact with persons who have acute upper respiratory tract infections on at least 3 separate occasions within the one year before the clinical onset of recurrent upper respiratory tract infections*
- *having sleep deprivation or circadian disruption, with an average of less than 6 hours of sleep in each 24 hours, for at least one month within the 3 months before the clinical onset of recurrent upper respiratory tract infections*
- *smoking at least 10 cigarettes per day for at least the one year before the clinical onset of recurrent upper respiratory tract infections*
- *being exposed to second-hand tobacco smoke in an enclosed space for at least 2 hours per day on more days than not for at least the 6 months before the clinical onset of recurrent upper respiratory tract infections*
- *having nasal obstruction from a deviated nasal septum or allergic rhinitis at the time of the clinical onset of recurrent upper respiratory tract infections*
- *having vitamin D deficiency, with a serum 25-hydroxyvitamin D level below 50 nanomoles per litre, at the time of the clinical onset of recurrent upper respiratory tract infections*
- *experiencing a severe or prolonged psychological stressor within the 3 months before the clinical onset of recurrent upper respiratory tract infections*
- *being exposed to air-conditioned or recirculated air with a relative humidity below 30 per cent for at least 8 hours per day for at least the 3 months before the clinical onset of recurrent upper respiratory tract infections*
- *consuming an average of at least 60 grams of alcohol per day for at least the 6 months before the clinical onset of recurrent upper respiratory tract infections*
- *inhaling respiratory irritants, including paint and solvent fumes, solder fumes or diesel exhaust, for at least 4 hours per day on at least 3 days per week for at least the 3 months before the clinical onset of recurrent upper respiratory tract infections*

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, nasal congestion, runny nose, cough, malaise and low-grade fever, and within a week of recovery a further similar illness began on 14 March 1998.

The diagnosis was made clinically by the medical officer on 5 March 1999 on six documented episodes of acute upper respiratory tract infection in the twelve months from 14 March 1998, each with sore throat, nasal congestion, rhinorrhoea, cough and fever, two complicated by sinusitis, with normal blood count and immunoglobulins excluding immune deficiency.

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

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 14 March 1998.

Upper Respiratory Tract Infections - Recurrent (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 October 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 2 October 2025;
- A ship's medical record (nasal fracture) by the ship's medical officer, dated 11 August 1996;
- An annual medical examination and allergy testing by the medical officer, dated 21 October 1997;
- A ship's medical record by the ship's medical officer, Bougainville, dated 14 March 1998;
- A ship's medical record and pathology by the ship's medical officer, dated 20 March 1998;
- A medical review and ENT referral by the medical officer, dated 5 March 1999;
- A ship's medical record by the ship's medical officer, Middle East, dated 10 September 2007;
- An ENT consultation and CT paranasal sinuses by the ENT surgeon, dated 14 February 2008.

Your service

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

20 January 1995 and 31 July 2012

Upper Respiratory Tract Infections - Recurrent (Worsening)

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

- *living or working in crowded communal accommodation with persons who have acute upper respiratory tract infections within the one month before the clinical worsening of recurrent upper respiratory tract infections*
- *having sleep deprivation or circadian disruption, with an average of less than 6 hours of sleep in each 24 hours, for at least one month within the 3 months before the clinical worsening of recurrent upper respiratory tract infections*
- *smoking at least 10 cigarettes per day at the time of the clinical worsening of recurrent upper respiratory tract infections*

- *inhaling airborne dust, smoke or fumes within the one month before the clinical worsening of recurrent upper respiratory tract infections*
- *being exposed to air-conditioned or recirculated air with a relative humidity below 30 per cent for at least 8 hours per day at the time of the clinical worsening of recurrent upper respiratory tract infections*
- *inability to obtain appropriate clinical management for recurrent upper respiratory tract infections*

Diagnosis: Recurrent (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 2 October 2025, and is supported by a medical review and ENT referral by the medical officer, dated 5 March 1999.

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:

- *living or working in crowded communal accommodation with persons who have acute upper respiratory tract infections within the one month before the clinical worsening of recurrent upper respiratory tract infections*
- *having sleep deprivation or circadian disruption, with an average of less than 6 hours of sleep in each 24 hours, for at least one month within the 3 months before the clinical worsening of recurrent upper respiratory tract infections*
- *smoking at least 10 cigarettes per day at the time of the clinical worsening of recurrent upper respiratory tract infections*
- *inhaling airborne dust, smoke or fumes within the one month before the clinical worsening of recurrent upper respiratory tract infections*
- *being exposed to air-conditioned or recirculated air with a relative humidity below 30 per cent for at least 8 hours per day at the time of the clinical worsening of recurrent upper respiratory tract infections*
- *inability to obtain appropriate clinical management for recurrent upper respiratory tract infections*

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, nasal congestion, runny nose, cough,

malaise and low-grade fever, and within a week of recovery a further similar illness began on 14 March 1998.

The diagnosis was made clinically by the medical officer on 5 March 1999 on six documented episodes of acute upper respiratory tract infection in the twelve months from 14 March 1998, each with sore throat, nasal congestion, rhinorrhoea, cough and fever, two complicated by sinusitis, with normal blood count and immunoglobulins excluding immune deficiency.

After the condition arose, it was worsened during your service. From June to August 2007, on warlike maritime service in the Middle East, you lived in a crowded frigate mess during repeated outbreaks of respiratory infection recorded in the ship's medical log, the last in August 2007, within the one month before the worsening on 10 September 2007. From June to September 2007 you worked a one-in-two watch system with boarding operations, averaging about 4.5 hours of sleep in each 24 hours, throughout the 3 months before the worsening on 10 September 2007. You continued to smoke about 20 cigarettes a day on deployment, recorded on 10 September 2007, at the time of the worsening. In August 2007 the ship operated in the northern Gulf in repeated dust storms and near burning gas flares, and you worked on the upper deck during boarding operations in dust and smoke, within the one month before the worsening. The frigate's operations room, where you stood your watches, was kept at a relative humidity of about 25 per cent, and you spent at least 8 hours a day there at the time of the worsening on 10 September 2007. MET.

This has then led to further investigations and the diagnosis of your condition of *Recurrent (Worsening)*. I have accepted your condition of *Recurrent (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 10 September 2007.

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