

FAQs GPs and other health professionals ask about supporting evidence.

## What types of existing evidence can I attach to help support an access request?

Some examples of the different types of evidence that can support a request are shown below:

Type of evidence	Examples
Evidence of disability. <ul style="list-style-type: none"> <li>• Diagnosis and treatment information</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital discharge plan</li> <li>• Mental health plan</li> <li>• Level of lesion SCI</li> <li>• ASIA Score</li> <li>• Modified Rankin Scale (Stroke)</li> <li>• DSM ID &amp; ADS</li> </ul>
Functional assessments related to disability <ul style="list-style-type: none"> <li>• Evidence of how permanent impairment impacts ability to function in everyday activities.</li> <li>• Activities person cannot complete in key domains.</li> <li>• Type and frequency of assistance needed.</li> </ul>	<ul style="list-style-type: none"> <li>• Specialist reports relevant to impairment</li> <li>• Treating OT, Psychologist, Speech Pathologist reports/ax</li> <li>• Ax from relevant government departments (Disability, Health, Education, Housing, Justice)</li> <li>• Statements by family members, carers, support workers</li> </ul>
Impact of disability on daily life	<ul style="list-style-type: none"> <li>• Case notes from service providers</li> <li>• Carer statement</li> <li>• Self report</li> </ul>

## If I, as a treating health professional, identify that my patient would benefit from funded disability supports, why isn't that enough evidence?

Legislation requires patients to meet specific criteria in order to be eligible for the Scheme and that adequate evidence is provided to demonstrate they fulfil these criteria.

As such, treating professionals are asked to support access requests by providing evidence that helps to validate the type and extent of a patient's impairment, as well as its permanency and functional impact.

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## Why can't Mental Health Referral Plans be used as evidence of diagnosis?

While a mental health care plan may state the patient's mental health condition (e.g. depression, schizophrenia), it is unlikely to detail the psychosocial impairment that has arisen from that condition.

The NDIS requires an outline and evidence of the specific impairment which has been diagnosed, not just the medical condition.

Find more information and detailed guidance on the [mental health and the NDIS](#) page.

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