SEEDS OCCUPATIONAL THERAPY

Functional Capacity Assessment

Peter James Renwick

SAMPLE REPORT · FICTITIOUS PARTICIPANT

Prepared to support a Disability Support Pension

Participant	Peter James Renwick
Date of birth	18 September 1969
Assessor	Nishadip K. Bal, Occupational Therapist
Practice	Seeds Occupational Therapy

Contents

CHAPTER 1

Participant Overview and Assessment Context

Fictitious sample participant — this report does not describe a real person.

Peter James Renwick is a 56-year-old man, born 18 September 1969, who lives alone in a rented single-storey unit in Corio, Geelong. He is divorced and has one adult daughter, Megan, who lives about twenty minutes away and visits twice weekly. A neighbour, Alan, occasionally helps with bins, short errands and informal welfare checks, but is not a regular carer. This Functional Capacity Assessment was completed for Seeds Occupational Therapy by Nishadip K. Bal, occupational therapist, following an assessment in July 2026.

Peter previously worked as a delivery driver, warehouse worker and forklift operator. He left school in Year 10 and has worked in physically based roles since his late teens, including freight handling, local delivery routes, stock movement, loading and unloading, and the basic administration attached to those roles. He has no recent experience of office-based work, and his computer use is limited to a phone, text messages and occasional email with help.

The assessment was requested to provide occupational therapy evidence about Peter's current daily function, support needs, risks and capacity for sustained work-like activity. Peter and Megan advised that the report is intended to support a Disability Support Pension application. Eligibility decisions rest with Services Australia.

Peter's function is affected by chronic lumbar spine pain with right-sided radicular symptoms, diabetic peripheral neuropathy affecting both feet, chronic obstructive pulmonary disease, and recurrent major depression associated with pain, functional decline and the loss of his working identity. His medication causes drowsiness, slowed thinking and dry mouth, particularly in the morning.

His main functional concerns are reduced walking and standing tolerance, difficulty sitting for sustained periods, unsafe bending and lifting, poor sleep, breathlessness on exertion, falls risk, reduced capacity for showering and meal preparation, difficulty attending appointments

independently, inconsistent medication and diabetes routines, and an inability to sustain reliable activity across a normal week.

The central question in Peter's presentation is not whether he can complete a task once. On a better morning, with medication timing and rest behind him, he can manage a small errand or a simple meal. The question is whether he can repeat tasks safely, predictably and with ordinary recovery across a day and a week. At present, the evidence does not indicate that he can do so reliably.

CHAPTER 2

DSP Assessment Purpose and Scope

This report has been prepared as functional evidence for Disability Support Pension purposes. It examines Peter's ability to perform daily living tasks, maintain routines, access the community, manage personal care, complete domestic activities, sustain attention and activity, and participate in work-like tasks reliably over time.

The assessment gives particular weight to endurance, repeatability, safety and recovery. A person may complete a task briefly, or on a good day, without holding the capacity for regular work or daily independence. For Peter, activity often produces symptom escalation later the same day or the following day, so an isolated observation is likely to overestimate his capacity.

This report does not rate or score function, and it does not determine eligibility for the Disability Support Pension or any other payment or scheme. Those decisions rest with Services Australia or the relevant decision-maker. The report also does not provide a vocational assessment, labour market assessment, legal opinion or insurance determination. Its role is to describe Peter's functional performance in occupational therapy terms and to give a reasoned opinion about whether his physical stamina, cognitive reliability, attendance capacity and recovery profile are consistent with sustained work-like activity.

Medical diagnosis, treatment stability and prognosis remain the responsibility of Peter's treating medical practitioners. Where diagnoses and treatment history are discussed, they are used to understand the functional impact of his health conditions.

CHAPTER 3

Sources of Information and Assessment Method

Information for this assessment was drawn from a structured occupational therapy interview with Peter, collateral information from his daughter Megan, intake questionnaires, functional examples provided by both, and standardised measures administered for this assessment.

Peter participated in an interview scheduled for late morning, as his pain and breathing are usually worse early in the day and his fatigue builds again by mid-afternoon. During the interview he changed position frequently, stood briefly at times to relieve back pain, and became visibly uncomfortable after about thirty minutes of sitting. He took a break midway through and moved to his recliner for the remainder of the discussion.

Megan provided collateral information about Peter's routines, medication, shopping, falls risk, mood, appointment attendance and the practical support she provides. Her account was broadly consistent with Peter's, although she described more concern about his safety and self-neglect than Peter first acknowledged.

Standardised and structured measures included the WHODAS 2.0, the Canadian Occupational Performance Measure, the Work and Social Adjustment Scale, the PSS-10, the DASS-21, a pain interference rating, ADL and IADL ratings, the HOME FAST home safety screen, and the ZBI-12 carer burden interview completed by Megan.

The report places particular weight on real-world examples: an abandoned supermarket trip; a podiatry appointment missed after a pain flare; washing left in the machine for two days because he could not bend and lift it out; sleeping in a recliner because bed transfers worsen pain; a near fall in the bathroom after numbness in his feet; and the failure of modified warehouse duties due to pain, fatigue and medication drowsiness.

CHAPTER 4

Medical, Diagnostic and Treatment Background

Peter reports the following diagnoses, as advised to him by his GP and treating team. He has chronic lumbar spondylosis with right-sided radicular symptoms, with back pain dating back more than ten years and significant worsening over the last three. He describes constant lumbar pain with intermittent sharp pain radiating down the right buttock and leg, and reduced tolerance for sitting, standing, bending and walking.

He has type 2 diabetes with peripheral neuropathy. He reports burning pain, numbness and altered sensation in both feet, worse at night and when walking on uneven surfaces. He also has chronic obstructive pulmonary disease, with breathlessness on exertion and a history of smoking, now ceased. He uses inhalers as prescribed, but breathlessness still limits walking, stairs and carrying.

Peter has recurrent major depression associated with chronic pain, the loss of his job, social withdrawal and reduced independence. He reports low motivation, irritability, poor sleep, reduced confidence and a sense that he has "become useless" since stopping work. Passive thoughts of hopelessness were raised and explored at interview; there was no current intent, and his GP is aware of and monitoring his mood. He has attended psychology intermittently, with attendance limited by pain, transport and low motivation.

His treatment history includes GP management, pain specialist review, physiotherapy, a hydrotherapy trial, analgesic and neuropathic pain medication, inhaler therapy, diabetes management, and advice on pacing and weight reduction. Physiotherapy helped him understand safer movement but did not restore reliable work capacity. Hydrotherapy was initially useful but became difficult to sustain because of transport, post-session fatigue and cost. His current medication reduces pain to a degree but causes drowsiness, slowed thinking and dry mouth, particularly in the morning.

From an occupational therapy perspective, Peter's presentation is chronic, multi-factorial and functionally significant, affecting physical stamina, mobility, domestic activity, community access, safety, sleep, concentration, mood and capacity for regular work-like activity. Medical opinion on prognosis and treatment stability rests with his treating doctors. Functionally, nothing in the information available to this assessment suggests he is likely to regain reliable capacity for physical employment or sustained sedentary work in the short term.

CHAPTER 5

Previous Function and Functional Decline

Peter worked continuously from the age of seventeen until his mid-fifties, apart from short gaps between jobs. His roles required early starts, driving, loading and unloading, pallet movement, forklift operation, repetitive lifting, long hours on concrete floors, customer contact and reliable attendance. He describes himself as "always working" and "not an office bloke", and work formed a large part of his identity. He was used to being physically capable, independent and financially self-reliant.

Outside work he maintained his unit, shopped independently, drove to visit family, attended local football matches and helped friends with small practical jobs.

His function declined gradually as back pain increased, with the sharpest change following repeated pain flares and failed attempts to remain at work. In 2024 he moved to lighter warehouse duties where possible. Those duties still required standing, walking, bending, reaching, scanning stock, short periods of seated administration and sustained attention across a shift. He could not sustain them: pain escalated across each shift, he became slower, and his sick leave increased. He ceased work in February 2025 after a flare involving severe back and right leg pain, and has not returned to paid employment.

Since stopping work his activity has contracted further. He no longer walks for recreation, rarely attends social events, and relies increasingly on Megan for shopping, transport and paperwork. These limitations sit against a long record of demanding physical employment and a household he previously ran without help. His present function represents a substantial reduction from that adult baseline.

CHAPTER 6

Functional Capacity Summary

Peter is independent in some basic tasks when conditions are favourable, but his daily function is substantially reduced and unreliable. His main barriers are pain, reduced standing and walking tolerance, breathlessness, neuropathic symptoms in both feet, poor sleep, medication drowsiness, low mood and reduced confidence.

On a better day he may shower, make toast or cereal, drive a short familiar route, attend a local appointment if parking is easy, and complete one small household task such as putting out rubbish or wiping the kitchen bench. Even then he generally needs rest afterwards and avoids stacking tasks together.

On a hard day, usually after poor sleep, a pain flare, a medical appointment or an attempted outing, he may stay in his recliner for much of the day, skip showering, eat only biscuits, toast or takeaway, delay medication, avoid phone calls and leave household tasks undone. Megan reports that on these days he often does not answer messages until late afternoon and can sound flat, confused or irritable.

His reported tolerances are standing for approximately five to ten minutes, walking approximately one hundred to two hundred metres on level ground with a walking stick, sitting for approximately twenty to thirty minutes before needing to change position, and lifting approximately three kilograms from waist height only. He avoids bending to floor level because it triggers back and leg pain and threatens his balance.

The defining feature is reliability. Peter can appear physically able during a brief appointment, particularly if he has rested beforehand, but that appearance does not carry across a full day or week. His function is held together by pacing, avoidance, medication, Megan's support, reduced expectations and prolonged rest, and it is not reliable at the level sustained work-like activity requires.

CHAPTER 7

Physical Stamina, Pain and Mobility

Peter walks with a single-point walking stick outdoors and sometimes indoors during pain flares. He can move short distances within the home but avoids unnecessary walking. Walking to the letterbox and back is usually manageable; walking the length of a supermarket or medical centre usually is not.

Standing is limited by lumbar pain, right leg symptoms and breathlessness. He can stand at the kitchen bench long enough to make toast, tea or a microwave meal, but not long enough to prepare a full meal. Queues are particularly difficult because he can neither pace nor sit, and he often abandons an errand rather than wait in line.

Sitting is limited as well. He cannot sit through a full movie, a long appointment or a work-like computer task. He shifts position, leans to one side or stands to relieve pressure. Driving is confined to short familiar routes because prolonged sitting increases back and leg pain and his medication can affect alertness.

Pain is present every day. He rates his usual pain at seven out of ten and his worst at nine out of ten. It increases with bending, lifting, walking, prolonged sitting, cold weather and poor sleep, and the neuropathic burning in his feet is worse at night, feeding into his sleep disruption.

Breathlessness further reduces his stamina. He becomes short of breath walking uphill, carrying shopping, rushing, or moving about in humid or cold weather, and needs frequent pauses despite his inhalers. On cold or humid days he often stays home rather than start an outing his breathing may not sustain.

His mobility impairment goes beyond reduced fitness. Physical activity can escalate pain and fatigue for the remainder of the day and sometimes into the next, which limits appointments, shopping, domestic tasks and any work-like activity requiring attendance, posture, movement and recovery within ordinary timeframes.

CHAPTER 8

Self-Care and Daily Routines

Peter can complete basic self-care physically, but not reliably or without cost. He showers about four times per week; on pain-flare days he washes at the sink with a washcloth instead. He has a non-slip mat and steadies himself against the wall, but has no shower chair, and he feels unsafe bending to wash his lower legs and feet because of back pain and reduced sensation.

Showering is effortful because it stacks standing, reaching, bending, drying and dressing into one sequence, and the steam and exertion leave him breathless; he sits on the edge of the bed to let his breathing settle before he dresses. He usually needs thirty to sixty minutes in his recliner afterwards before attempting anything else, and on appointment days he showers the night before to conserve energy for the day itself.

Dressing is slower than it was. He avoids socks where he can because bending to his feet triggers back pain, wears the slip-on shoes Megan bought him most days, and chooses loose clothing because buttons and belts are difficult when pain is high. Going sockless in slip-ons sits poorly with the foot care his diabetes requires, and the daily foot checks he has been advised to complete rarely happen: bending to inspect his feet is painful and he cannot see the soles.

Toileting is independent, but night-time bathroom trips carry risk. His feet are numb and he is unsteady when he first stands, so he keeps a lamp beside the recliner after nearly tripping on the way to the bathroom in the dark.

Eating depends on what is available. He can feed himself once food is prepared, but preparing it is the unreliable step, and on low-capacity days his intake narrows to toast, cereal, biscuits or takeaway, which affects his diabetes management.

Sleep is poor. He often sleeps in the recliner because lying flat increases back and leg pain, and he wakes repeatedly with pain, neuropathic burning or breathlessness. Poor sleep then worsens his pain, mood and daytime concentration.

Taken together, his self-care is partially independent but fragile: slow, inconsistent, and shaped by pain, breathlessness, falls risk and the recovery each task demands.

CHAPTER 9

Meal Preparation, Domestic Tasks and Home Management

Peter can make toast, cereal, sandwiches, tea and microwave meals. He cannot reliably prepare meals that involve chopping, standing at the stove, lifting pots, draining water or cleaning up afterwards, and he avoids carrying hot pans because of back pain, foot numbness and fear of losing his balance.

Megan cooks twice weekly and leaves containers in the fridge, and he otherwise relies on frozen meals and takeaway. When prepared food runs out, his meals become simpler and less suitable for his diabetes. He knows what he "should eat"; he cannot stand, plan and cook consistently enough to follow through.

Cleaning is limited to very brief tasks such as wiping a bench, rinsing a cup or putting rubbish near the door. He avoids vacuuming because pushing and twisting aggravate his back, and the bathroom is not cleaned regularly. Laundry is difficult at every step: bending to the machine, lifting wet clothes, hanging washing. Megan reports that washing is sometimes left in the machine for one to two days until she visits.

The unit shows the effect. At assessment there were dishes in the sink and laundry visible in the hallway, and Peter apologised several times for the state of the place. This appeared to reflect functional limitation rather than indifference. As he put it, "I see it, I just can't get on top of it."

CHAPTER 10

Community Access, Transport and Appointments

Peter holds a driver's licence and drives short familiar routes in daylight. He avoids driving after taking stronger pain medication. This assessment has not examined his fitness to drive; that question rests with his GP and treating team. Megan does most appointment transport. He avoids buses because walking to the stop, standing while waiting, steps, crowding and the lack of guaranteed seating are not manageable for him.

Shopping illustrates the load. In May 2026 he attempted a supermarket trip alone. He parked close to the entrance, but walking the aisles brought on breathlessness and increasing back and leg pain. He left with three items, sat in the car for twenty minutes, then drove home. Megan has done most of the grocery shopping since, working from a paper list Peter keeps on the bench.

Appointments require planning and recovery. He missed a podiatry appointment after a night of severe neuropathic pain and poor sleep: he could not safely drive and had no energy left to arrange other transport. Podiatry is among the appointments that matter most for him, given the neuropathy and his diabetes, and among the least reliably attended. He has cancelled physiotherapy sessions when attending would have consumed the energy he needed for showering and meals. A local GP visit works when Megan drives and the appointment is late morning, though even with close parking he usually stops once between the car and the clinic door to catch his breath. Longer appointments, unfamiliar locations and hospital outpatient clinics are harder because of parking, long corridors, waiting and sitting.

His community participation has narrowed. He no longer attends local football because of the walk from parking, the hard seating and the crowds. He sees friends rarely and mostly speaks by phone. His world has contracted to the unit, short medical appointments and occasional family-supported outings.

CHAPTER 11

Communication, Cognition and Self-Management

Peter communicates clearly in conversation when rested. His cognitive efficiency drops with pain, fatigue, poor sleep and medication. He loses track of tasks, misses medication times, and avoids paperwork because he cannot hold concentration on it. In one recent week he paid the same bill twice because he could not recall whether it had been done; he has also missed bills entirely.

Megan reports that he can sound "foggy" in the morning after poor sleep or medication, may repeat questions, forget appointment details or misread written instructions. He has no diagnosed cognitive disorder; functionally, his concentration, memory and follow-through are unreliable under load.

His literacy is adequate for simple written material, but forms, online portals and complex letters defeat him quickly and he gives up frustrated. He answers calls from people he knows and lets unknown numbers ring out, and paperwork generally waits until Megan arrives. He relies on her to read government correspondence, complete online tasks and keep documents in order.

Self-management is further reduced by low initiation and mood. He often knows what needs doing and cannot start it. Booking appointments, following up referrals, arranging medication repeats, contacting services and paying bills wait until Megan prompts or does them with him.

Medication is mostly self-managed but not fully reliable. He uses a weekly pill organiser, which Megan fills with him after he previously confused morning and evening tablets. He has missed diabetes medication on several occasions and sometimes delays his inhaler until breathlessness is more severe.

These limitations matter for work capacity. Even sedentary or light duties require attention, reliability, task initiation, communication, problem solving and follow-through, and Peter's

cognitive reliability is reduced, particularly when pain, poor sleep and medication effects combine.

CHAPTER 12

Emotional Function, Adjustment and Stress Tolerance

Peter's mood has declined markedly since he stopped work. He describes feeling ashamed, frustrated and dependent. He spent his adult life "doing physical work" and now feels he has "nothing useful to offer". The loss of employment has cost him confidence, identity and purpose, and he reports low mood most days, reduced motivation, irritability, poor sleep and withdrawal from friends.

Passive thoughts of hopelessness were explored directly at interview. Peter described thinking "there's not much point" when pain is severe. He denied any current intent or plan, and no evidence of self-harm intent or behaviour was identified at assessment. His GP is aware of his mood symptoms and monitors them.

His stress tolerance is reduced. Forms, appointments, financial letters and discussions about work capacity overwhelm him, and he avoids tasks that make him feel incompetent, particularly anything online. The avoidance eases distress in the moment and costs him later, in missed deadlines and greater reliance on Megan.

Pain and depression feed each other. Pain reduces activity and sleep; poor sleep lowers mood and concentration; low mood reduces initiation; and reduced activity brings further deconditioning and isolation. His mood does not replace the physical impairment picture, but it compounds it and erodes his ability to apply strategies consistently.

Support lands best when it is practical, respectful and non-shaming. He responds to clear routines and small achievable tasks rather than general encouragement to become more active; pushing past his physical limits has previously ended in pain flares and further withdrawal.

CHAPTER 13

Safety, Falls Risk and Daily Reliability

Peter's safety risks arise from neuropathy, pain, breathlessness, medication side effects and reduced mobility. He has had one fall in the past twelve months and several near falls. The fall happened at night when he caught his foot on a mat while standing from the recliner; he landed on his side and did not seek medical care, and Megan noticed the bruising two days later. The near falls include one in the bathroom, where reduced foot sensation and unsteadiness when turning have nearly brought him down.

Bathroom risk extends beyond the near falls: difficulty washing his lower legs and feet, reduced sensation, and unsteadiness turning in the shower. He avoids showering when he is very drowsy or when leg pain is severe, which further reduces his hygiene consistency.

In the kitchen he no longer lifts pots of boiling water and has stopped cooking pasta because draining it felt unsafe. On one occasion he left the stove on low after making soup and only noticed later from the smell. He has moved to microwave meals largely for this reason.

Medication safety is partly held by the pill organiser and Megan's involvement, but errors remain possible when he is tired or drowsy, and his diabetes control is affected by the inconsistency of his meals. Reduced sensation adds a further risk: a cut, blister or rubbing shoe may not be felt, and because he cannot easily inspect his feet, a minor injury could go unnoticed until it is established.

In the community his safety depends on conditions he cannot always control: close parking, available seating, short distances and familiar layouts. He avoids unfamiliar places because he worries about exactly those things, and if pain escalates partway through an outing he may not be able to finish it safely.

The reliability risk sits over all of this. His capacity fluctuates, and a task completed safely one day may be unsafe or impossible the next. That affects self-care, meals, appointments, driving, shopping and any expectation built on predictable attendance.

CHAPTER 14

Informal Supports and Sustainability

Megan is Peter's main support. She visits twice weekly after work and brings groceries, cooks, helps with laundry, sets up medication with him, drives him to appointments, deals with paperwork and provides emotional encouragement. She also phones or texts most days to check that he has eaten and taken his medication.

Megan works full time and has two school-aged children. Her support is caring and consistent, and it is not unlimited. She worries that her father is becoming more dependent, that there is no backup if she is unavailable, and she feels guilty when she cannot visit.

Alan, the neighbour, helps occasionally with bins and short errands. This is goodwill, not a reliable support arrangement. Beyond Megan and Alan, Peter has little practical help; he is embarrassed to ask friends and has withdrawn from most of them.

Megan's support also masks the extent of the impairment. Because she covers groceries, meals, paperwork and transport, Peter appears more stable than he would be living without support. If she were unavailable for even two weeks, his meals, medication routine, laundry, appointment attendance and household administration would all be at risk.

Formal support would reduce the practical load on Megan, ease the pressure on the father–daughter relationship, and let Peter hold his basic routines with planned help rather than crisis-driven rescue. The aim is a sustainable level of family involvement, with the practical care load carried elsewhere.

CHAPTER 15

Standardised Measures and Functional Interpretation

Standardised measures were administered to support clinical interpretation of Peter's function, and are read here alongside the interview, collateral information and daily examples rather than as standalone findings.

Peter's WHODAS 2.0 profile showed severe difficulty in mobility, household responsibilities and participation, with moderate difficulty in cognition and self-care. He reported severe difficulty standing for long periods, walking long distances, getting household tasks done, joining community activities and dealing with the emotional impact of his health condition. Mobility and life activities were his most affected domains, which matches the daily picture in this report.

On the Canadian Occupational Performance Measure, Peter identified five priority occupational performance issues.

Occupational performance issue	Importance	Performance	Satisfaction
Showering safely and consistently	9	4	3
Preparing simple meals without relying on Megan	10	3	2
Managing groceries and essential errands	8	2	2
Attending medical appointments reliably	9	4	3
Keeping the unit clean enough to feel comfortable	8	2	2

Mean performance was 3.0/10 and mean satisfaction 2.4/10, indicating low current performance in activities Peter rates as highly important. His priorities sit squarely in basic daily living rather than discretionary activity.

His Work and Social Adjustment Scale total was 31/40, indicating severe functional interference. Work was rated 8, home management 8, social leisure 6, private leisure 5 and close relationships 4.

The PSS-10 total was 25/40, indicating a moderate level of perceived stress. DASS-21 scores were Depression 22, Anxiety 12 and Stress 24, consistent with severe depressive symptoms and moderate anxiety and stress. These results fit his reported loss of identity, reduced activity, pain-related frustration and avoidance of complex tasks.

Peter rated pain interference as severe across walking, sleep, household tasks, mood and enjoyment of life. Interference was lower for brief seated conversation and rose sharply with prolonged sitting, consistent with his presentation at interview.

His basic ADL ratings showed partial independence with increased time, reduced frequency and safety concerns. His IADL ratings showed a need for assistance with shopping, meal preparation, cleaning, laundry, transport, medication setup and financial administration.

The HOME FAST screen identified hazards consistent with the history in this report: loose floor mats of the kind involved in his fall, limited night lighting between the recliner and the bathroom, the absence of shower seating or rails, and storage low enough to require bending.

Megan's ZBI-12 score was 17 out of 48, in the moderate range for carer strain. She endorsed worry about Peter's safety, pressure balancing his support with work and parenting, and concern about future decline.

Across the measures the pattern is consistent with the rest of this assessment. The impairments are not confined to one task or domain; they run through mobility, domestic function, self-care reliability, community access, emotional wellbeing, health management and work-like capacity.

CHAPTER 16

Functional Evidence Aligned to the DSP Impairment Tables

This chapter lines the functional evidence of this report up against the domains the Impairment Tables cover, so it can be read alongside the medical evidence without working back through the chapters above. It assigns no ratings and no points and makes no finding about eligibility; the rating and the decision rest with Services Australia. The domains carrying the most weight in Peter's case are physical exertion and stamina, spinal function, lower limb function, and mental health, each described in terms of what he can do reliably and repeatedly rather than once on a good day.

Functions requiring physical exertion and stamina are severely restricted. Peter cannot sustain standing, walking, bending, lifting or continuous light activity across a normal day. His breathlessness compounds the musculoskeletal limits, ordinary activities such as showering, shopping or laundry demand prolonged recovery, and exertion on one day routinely reduces what he can do later that day and the next.

Spinal function is impaired by chronic lumbar spondylosis with right-sided radicular symptoms. He avoids bending to floor level, tolerates sitting for twenty to thirty minutes before needing to move, sleeps in a recliner because lying flat aggravates his back and leg pain, restricts driving because of sitting intolerance, and lifts no more than about three kilograms from waist height.

Lower limb function is affected by both the radicular leg symptoms and bilateral diabetic peripheral neuropathy. He walks with a single-point stick, has reduced and unreliable sensation in his feet, is unsteady on first standing and at night, has fallen once in the past year and nearly fallen several times, and cannot manage uneven ground, queues or sustained standing.

Mental health function is impaired by recurrent major depression. He has low mood most days, reduced motivation and initiation, irritability, social withdrawal, poor sleep, reduced stress tolerance and avoidance of demanding tasks, with passive hopelessness when pain is severe, no

current intent, and monitoring by his GP. The depression interacts with pain and poor sleep and reduces his capacity to compensate for the physical impairments.

Peter also describes reduced concentration, memory lapses and slowed thinking. These are functionally real and are documented in this report, but they occur in the context of pain, poor sleep, medication effects and mood rather than a diagnosed neurological or cognitive condition. Whether they are considered within the mental health domain or elsewhere is a matter for the assessing officer with the medical evidence.

Two further points bear on how this evidence should be read. First, Peter's function fluctuates, and what matters is what he can do reliably and repeatedly over time; his best-day performance overstates his usual capacity, and single observations should be weighted accordingly. Second, whether his conditions are fully diagnosed, treated and stabilised is a matter for the medical evidence; functionally, his presentation has persisted and worsened despite the treatment reported to this assessment, including physiotherapy, hydrotherapy, pain specialist review, medication and self-management advice.

Taken together, the functional evidence across these domains is not consistent with reliable work-like activity across a normal week.

CHAPTER 17

Work, Study and Productivity Capacity

Peter is not currently working or studying. He ceased work in February 2025 after modified warehouse duties failed, and his previous roles in delivery driving, warehouse work and forklift operation required standing, walking, lifting, bending, driving, sustained attention and dependable attendance.

His current physical capacity is not compatible with that work. He cannot safely lift, bend repeatedly, walk warehouse distances, stand for extended periods, keep pace in a fast environment or sustain a shift without symptom escalation. Forklift and delivery work would also carry safety concerns given his medication drowsiness, foot numbness, pain flares and limited sitting tolerance.

Sedentary work is not a realistic immediate alternative. He has limited computer literacy, no office work history, a sitting tolerance of twenty to thirty minutes, concentration reduced by pain and medication, and real difficulty with forms and digital systems. Retraining would be a precondition for any desk-based role, and his current capacity does not support reliable participation in retraining or study.

He can complete brief productive tasks at home, such as sorting mail with Megan, making a phone call or writing a simple list. These do not translate into work capacity. Work requires attendance, task persistence, pace, accuracy, communication, tolerance of supervision and recovery within ordinary work cycles, and Peter's presentation does not meet those demands.

At the time of assessment, Peter does not demonstrate capacity to return to his previous work or to sustain other work for which he is reasonably suited by education, training or experience. Any opinion about permanent incapacity for work sits alongside the medical evidence and the requirements of the relevant decision-maker.

CHAPTER 18

Recommendations, Implementation Priorities and Final Clinical Opinion

The recommendations below are made from an occupational therapy functional perspective. They are aimed at safety, stability in basic daily routines, reliable attendance at health care, reduced strain on informal support, and prevention of further functional deterioration, rather than at immediate work restoration, while allowing safe participation within Peter's current limits. They sit alongside medical advice and any treating-practitioner recommendations.

Occupational therapy intervention

Peter would benefit from occupational therapy focused on energy conservation, safe movement strategies, shower and kitchen safety, home setup, pacing, falls prevention, daily routine planning, medication routine supports and graded participation in essential activities. The emphasis should be practical: building a small number of dependable routines rather than expanding activity for its own sake, and interrupting the cycle of overexertion followed by days of recovery.

Support worker assistance

Practical support worker assistance is recommended for meal preparation, light domestic tasks, laundry, shopping, appointment preparation and supported community access. Support should be paced and participation-preserving, helping him do what he safely can while covering what he cannot, rather than doing everything for him or pushing him past safe limits. This assistance would directly reduce the practical load currently carried by Megan.

Home safety review and equipment

A home safety review is recommended covering bathroom safety, seating, night lighting, trip hazards, laundry setup, kitchen safety and safer storage to reduce bending, following the hazards identified on screening. Equipment for consideration, subject to occupational therapy

assessment, includes a shower chair, handheld shower hose, perching stool, long-handled aids, and a trolley or lightweight domestic equipment.

Medication and diabetes routine supports

Peter would benefit from a simplified medication system, including pharmacy-packed medication if his GP and pharmacist agree it suits him, visible prompts, phone reminders, and check-ins from Megan or a support worker where needed. The aim is fewer missed doses and less cognitive load, developed with his GP and pharmacist. More consistent meals, supported as above, would also steady his diabetes management.

Continuing medical and psychological care

Peter should continue medical management with his GP, pain specialist, diabetes care providers and respiratory supports. Continuing psychological support is recommended for adjustment to functional loss, mood, pacing, pain coping and identity change, delivered in the practical, non-shaming style he responds to. These remain mainstream health responsibilities and are noted here because they underpin the functional recommendations.

Implementation priorities and review

Implementation should begin with safety and daily stability: shower safety and equipment, meal reliability, medication routines, laundry and essential appointment access. Work and study goals should not be treated as immediate rehabilitation targets while daily function, pain, sleep and activity tolerance remain unstable. Progress should be reviewed at approximately twelve weeks against practical indicators — shower consistency, meal reliability, medication accuracy, falls and near falls, and appointment attendance — with supports adjusted according to what the review shows.

Final clinical opinion

Peter presents with substantially reduced functional capacity arising from chronic lumbar spine pain with radicular symptoms, diabetic peripheral neuropathy, chronic obstructive pulmonary disease and recurrent major depression associated with pain and functional loss. These

impairments substantially affect his physical stamina, mobility, self-care reliability, domestic function, community access, self-management, mood and capacity for work-like activity.

His presentation is defined by limited endurance, poor recovery, fluctuating capacity and reliance on Megan's support. He can complete some tasks briefly under favourable conditions, but he cannot sustain ordinary daily activities reliably across a week without substantial pacing, avoidance, rest and informal support.

From an occupational therapy functional perspective, at the time of assessment, Peter does not demonstrate the physical stamina, sitting tolerance, cognitive reliability, attendance capacity or recovery profile required to sustain work-like activity for fifteen hours per week on an ongoing basis. This opinion is based on functional evidence. It does not determine eligibility for the Disability Support Pension or any other payment; that decision rests with Services Australia.

Without appropriate support, Peter is at foreseeable risk of worsening self-care, poor nutrition, medication errors, missed appointments, falls, increased isolation, further deconditioning, increased carer strain and deterioration in his physical and psychological wellbeing.

Authorisation

This functional capacity assessment was prepared by the undersigned. The opinions expressed reflect my clinical judgement, based on the assessment activities and source material described in this report.

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Signed on 6 July 2026