Medical indemnity claim form

Please complete all fields

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| Section 1: Your organisation |
| Organisation name |       | Campus (if applicable) |       |
| Contact name and title |       | Contact email and phone |       |
| Urgent?Click on the circle if you need action in less than 3 days (e.g. if a Writ has been served, we must arrange legal representatives to file a Notice of Appearance on your behalf within 10 days) | [ ]  Yes [ ]  No | Request VMIA contact?Click on the circle if you need us to contact you to discuss this matter – we would normally only do so if the matter required urgent attention such as appointing a legal advisor | [ ]  Yes [ ]  No |

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| Section 2: Source of claim |
| Select one only | [ ]  Clinical Audit[ ]  Complaint via the Office of the HSC[ ]  Complaint direct to Health Service  (without request for compensation)[ ]  Coronial Matter[ ]  FOI - Other Insurer[ ]  FOI - Patient / Family[ ]  FOI – Solicitor | [ ]  Incident Report[ ]  Medical Record Review[ ]  Other[ ]  Any written request for compensation  (Inc. letter of Demand under Wrongs Act)[ ]  Tribunal (e.g. AHPRA, VCAT)[ ]  Writ |

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| Section 3: Claimant (person seeking compensation) |
| Is the claimant the patient? | [ ]  Yes (go to Section 4) [ ]  No | If no, relationship to the patient | [ ]  Spouse or domestic partner[ ]  Primary carer[ ]  Parent[ ]  Sibling[ ]  Other family member/relative[ ]  Agent/guardian/or  enduring power of attorney[ ]  Non-family |
| Claimant first name |       | Claimant family name |       |
| Claimant gender |       | Claimant date of birth |       /       /       |

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| Section 4: Episode of care details to which the notification relates |
| Patient first name |       | Claimant family name |       |
| Patient gender |       | Patient date of birth |       /       /       |
| Unit/Medical Record No. |       | Admission status | [ ]  Public [ ]  Private |
| Brief description of admitting provisional/confirmed diagnosis and any relevant co-morbidities which may have affected admission (e.g. Type 2 Diabetes, Congestive Cardiac Failure, etc) |       |

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| Section 5: Incident details |
| Date of incident |       /       /       | Date first aware of incident |       /       /       |
| Incident description Short description of adverse event notified or claim madee.g. alleged delay in diagnosis of ectopic pregnancy leading to rupture of fallopian tube requiring salpingectomy |       |
| Factual account of incident/circumstance(Please do not provide opinion on liability or causative factors) |       |
| Clinical specialty  | [ ]  Allied Health & Other  Therapy Services[ ]  Ambulance/Pre-Acute Care Service[ ]  Anaesthetics[ ]  Breast Surgery[ ]  Cardiology[ ]  Cardiothoracic Surgery[ ]  Clinical Pharmacology[ ]  Colon & Rectal Surgery[ ]  Community Mental Health[ ]  Dental/Oral Surgery[ ]  Dermatology[ ]  Ear/Nose/Throat (ENT)[ ]  Emergency Medicine[ ]  Endocrinology[ ]  Gastroenterology[ ]  General Medicine[ ]  General Practice | [ ]  General Surgery[ ]  Genetics[ ]  Gerontology[ ]  Gynaecology[ ]  Haematology[ ]  Immunology/Allergy[ ]  Infectious Disease[ ]  Intensive Care[ ]  Inpatient Mental Health Services[ ]  Maxillofacial Surgery[ ]  Medical Imaging[ ]  Neonatology[ ]  Nephrology[ ]  Neurology[ ]  Neurosurgery[ ]  Obstetrics[ ]  Oncology[ ]  Ophthalmology | [ ]  Orthopaedics[ ]  Other[ ]  Paediatrics[ ]  Palliative Care[ ]  Pathology[ ]  Plastic Surgery[ ]  Preventative Medicine[ ]  Primary &  Community Services[ ]  Radiation Oncology[ ]  Residential Aged  Care Services[ ]  Respiratory Medicine[ ]  Residential Mental Health[ ]  Rheumatology[ ]  Subacute Care & Rehab[ ]  Trauma Service[ ]  Urology[ ]  Vascular Surgery |
| Please list relevant DRG codes |       |
| Area of incident | [ ]  Accident & Emergency[ ]  Inpatient | [ ]  Outpatient[ ]  Community |  |
| Have you received written correspondence from claimant regarding incident? | [ ]  Yes [ ]  NoIf yes, please attach any relevant documents |
| Has Open Disclosure occurred? | [ ]  Yes [ ]  No [ ]  Unknown |

Any personal information you provide directly (or provided by a health service under s141 of the Health Services Act 1988) in this Form is being collected by the VMIA for the purpose of administering VMIA’s functions, under s6 of the Victorian Managed Insurance Authority Act 1996 (Vic), namely to provide insurance, risk advisory and claims handling services. Any personal information you provide will be treated according to the requirements of the Privacy and Data Protection Act 2014 (Vic), the Information Privacy Principles, the Victorian Protective Data Security Standards, the Health Records Act 2001 (Vic) and the Health Privacy Principles. VMIA will not act or engage in any practice that contravenes these provisions. Information will be handled in line with VMIA's Privacy Policy. You have the right to access and correct your personal information. Requests for access should be sent to the Privacy Officer, VMIA, PO Box 18409, Collins Street East, VIC 8003 or privacy@vmia.vic.gov.au.