**Title and full name of practitioner:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Practice location:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Month:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| Date of contact with patient | Time of contact with patient | Patient's Full Name (or Medical Record Number) | Contact Phone Number | Patient’s DOB | Supervisor’s Full Name | Date and time of consultation with Supervisor |
| --- | --- | --- | --- | --- | --- | --- |
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I confirm I consulted with the supervisor in-person or via the telephone and discussed the management of each and every patient who presented with concerns relating to Domestic and Family Violence, on every occasion.

**Practitioner:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Office of the Health Ombudsman

**EMAIL:** [**monitoring@oho.qld.gov.au**](mailto:monitoring@oho.qld.gov.au)

**CALL: 07 3158 1329**

**FAX: 07 3319 6350**

I confirm the practitioner consulted with me regarding the abovenamed patients as stated above.

**Primary Supervisor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Alternate Supervisor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_