OFFICE OF THE HEALTH OMBUDSMAN

Notification form

If you need help to fill in this form, call us on 133 OHO (133 646) between 9:30 am and 4:00 pm, Monday to Friday.

1. Your details

Title: _____ Given name(s):_____

Last name:_____

Date of birth: ___ ___ / ___ ___ / ___ ___ ___ ___ Preferred language: _____

Preferred method of contact: ◯ Email ◯ Post ◯ Phone Daytime telephone:_____

Postal address: ◯ Home ◯ Work ◯ Other: _____

_____

Suburb/town: _____ State/territory: _____ Post code:_____

Email: _____

What is your role in this notification? ◯ Practitioner ◯ Employer ◯ Education provider

If you are a practitioner, what is your relationship to the person in question?:

You are the person's: ◯ Senior ◯ Peer ◯ Junior ◯ Other: _____

Your profession: _____ Registration number: _____

2. Notification type

Have you formed the belief this is a voluntary or mandatory notification? ◯ Mandatory (see below) ◯ Voluntary (skip to 3)

Mandatory notifications only

If the person is a *health practitioner*:

I have formed the reasonable belief that the practitioner has behaved in a way that constitutes notifiable conduct as they have:

- ☐ practised their profession while intoxicated by alcohol or drugs
- ☐ engaged in sexual misconduct in connection with the practice of their profession
- ☐ placed the public at risk of substantial harm in their practice of their profession because they have an impairment
- ☐ placed the public at risk of harm because they have practiced their profession in a way that constitutes a significant departure from accepted professional standards.

If the person is a *student*:

- ☐ I have formed the reasonable belief that the student has an impairment that, in the course of the student undertaking clinical training, may place the public at substantial risk of harm.

3. Who is the notification about?

Title: _____ Given name(s): _____

Last name: _____

Previous name(s) or alias, if known: _____

Date of birth, if known: ___ ___ / ___ ___ / ___ ___ ___ ___ Daytime telephone: _____

Profession/specialty: _____ Registration number: _____

Which board(s) are they registered with? _____

Where are they currently working (e.g. GP clinic, dental practice)? _____

In what capacity/position held? _____

Location (e.g. street address, ward number): _____

Suburb/town: _____ State/territory: _____ Post code: _____

Email: _____

4a. Your concerns – what, how and who

Please describe your concerns, including **what** happened, **how** it happened and **who** was involved.
Where appropriate, please include details of the type of treatment involved, names and contact details of any witnesses.
Attach another page if you need more space and **include copies of any supporting documents**—e.g. reports, photos, etc.

Please also include patient(s) details, if known.

4b. Your concerns – where and when

Where was the health service provided?

- ☐ Hospital – in patient
- ☐ Practitioner's office/consulting rooms
- ☐ Pharmacy
- ☐ Hospital – out patient
- ☐ Primary care facility
- ☐ Patient's home
- ☐ Other: _____

When was the health service provided?: ___ ___ / ___ ___ / ___ ___ ___ ___

If your concerns relate to multiple dates, please record the latest relevant date.

If there has been a delay between when you became concerned and this notification, please explain the delay:

Have you discussed your concerns directly with the person? ◯ Yes ◯ No

How did the matter come to your attention?

☐ Directly observed by me ☐ Via another person ☐ Via patient(s) ☐ Disclosed to me by the person

☐ Record review/audit ☐ Other: _____

5. Have you tried to resolve your complaint?

Have you contacted us before about this complaint? ◯ No ◯ Yes Case #: _____

Have you already complained to the health service provider or to another entity?

☐ No ☐ Yes, to the health service provider Date of complaint: ___ ___ / ___ ___ / ___ ___ ___ ___

☐ Yes, another entity (name): _____ Date of complaint: ___ ___ / ___ ___ / ___ ___ ___ ___

Give them time to respond before you complain to us. If you have received a response to your complaint, please attach a copy.

Does this relate to: ☐ Impairment ☐ Conduct

Has the complaint been reported to the Crime and Corruption Commission?

◯ No ◯ Yes If yes, please provide date and reference number: _____

Comments (e.g. assessed and referred/assessed at Cat 3 referral not required):

_____

Has the information provided in the complaint been assessed as a public interest disclosure*?

◯ No ◯ Yes If yes, who is the discloser? _____

* Under the *Public Interest Disclosure Act 2010*

5a. How many were affected?

How many people were affected?

Comment:

☐ Unsure ☐ Zero

☐ One ☐ Two or more

5b. How were they affected?

In what way were people affected?

☐ Unsure ☐ Minor psychological or emotional harm ☐ Significant or major psychological or emotional harm

☐ No harm apparent ☐ Minor physical harm ☐ Significant or major physical harm

☐ Drug dependency ☐ Latent or potential harm (e.g. exposed to radiation, risk of infection) ☐ Death

☐ Other: _____

6. Information collected for de-identified, statistical use only

Your gender identity: _____ Your country of birth: _____

What is your ethnic/cultural identity? ☐ Aboriginal ☐ Torres Strait Islander ☐ Australian South Sea Islander

☐ Other: _____

How did you hear about us? ☐ Health service provider ☐ Media/advertising ☐ Family/friend ☐ Lawyer

☐ Professional body/board ☐ Other: _____

7. Privacy and confidentiality

In managing your notification, we will collect personal information about you. We comply with the Information Privacy Principles in the *Information Privacy Act 2009*.

We are required to give your notification to the person you have identified. If there is any information you don't want them to receive, please let us know. We will also advise the Australian Health Practitioner Regulation Agency of your notification.

We will not disclose personal information unless you consent or the disclosure is allowed, authorised or required by law.

You can apply to access or amend documents held by us under the *Information Privacy Act 2009* and the *Right to Information Act 2009.* Some documents—for example those containing the personal information of other people—may be exempt from access.

Visit our website to read our Privacy Statement and to find out how to access/amend documents at www.oho.qld.gov.au.

☐ I acknowledge that the Office of the Health Ombudsman may send the information I provided in this form to the health practitioner or student named.

☐ I understand it is an offence to knowingly provide false or misleading information to the Office of the Health Ombudsman.

Signed: _____ Date: ___ ___ / ___ ___ / ___ ___ ___ ___

8. Send your notification to us

By mail to: **PO Box 13281 George Street, Brisbane Qld 4001**

By fax to: **07 3319 6350**

By email to: **complaints@oho.qld.gov.au**

If you are sending your notification by email, please check your junk mail settings to ensure you see any emails we send you.

We will contact you within 14 days of receiving your notification.

For more information about our process visit www.oho.qld.gov.au.