



Notification form

If you need help to fill in this form, call us on 133 OHO (133 646) between 9 am and 5 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 practised their professional 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?

- | | | |
|--|--|--------------------------------------|
| <input type="radio"/> Hospital – in patient | <input type="radio"/> Practitioner's office/consulting rooms | <input type="radio"/> Pharmacy |
| <input type="radio"/> Hospital – out patient | <input type="radio"/> Primary care facility | <input type="radio"/> Patient's home |
| <input type="radio"/> 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?

- | | | | |
|---|--|--------------------------------------|---|
| <input type="radio"/> Directly observed by me | <input type="radio"/> Via another person | <input type="radio"/> Via patient(s) | <input type="radio"/> Disclosed to me by the person |
| <input type="radio"/> Record review/audit | <input type="radio"/> Other: _____ | | |

5a. How many were affected?

How many people were affected?

Comment: _____

- | | |
|------------------------------|-----------------------------------|
| <input type="radio"/> Unsure | <input type="radio"/> Zero |
| <input type="radio"/> One | <input type="radio"/> Two or more |

5b. How were they affected?

In what way were people affected?

- | | | |
|--|--|--|
| <input type="radio"/> Unsure | <input type="radio"/> Minor psychological or emotional harm | <input type="radio"/> Significant or major psychological or emotional harm |
| <input type="radio"/> No harm apparent | <input type="radio"/> Minor physical harm | <input type="radio"/> Significant or major physical harm |
| <input type="radio"/> Drug dependency | <input type="radio"/> Latent or potential harm
(e.g. exposed to radiation, risk of infection) | <input type="radio"/> Death |
| <input type="radio"/> 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.