MINTO Medical Centre

PATIENT WORKCOVER / CTP QUESTIONNAIRE

Please complete the form below and return to reception to be included with your file – If you are unsure or need assistance, please ask reception or your Doctor

Surname:_____ First Name: _____

Address:_____

Home Tel:_____Mobile:_____

Occupation:_____ D.O.B._____

Please advise the date when the injury / Accident Occurred

Day_____ Date_____Time_____AM/PM

Is your injury related to : (Please circle)

WORK MOTOR VEHICLE ACCIDENT

PUBLIC LIABILITY VICTIMS COMPENSATION

OTHER_____

If WORK Related, please advise the following details:

(Also note that you must complete a work injury claim form with your employer)

Name of your employer:_____

Employers Address: _____

Employers Phone Number: _____

Have you reported your injury to you employer: YES NO

If yes, Who did you report the incident to ?: _____

When did you commence work with your employer?: _____

Please describe your duties of employment:

_____

_____

_____

How long have you been doing this type of duty?: _____

Please complete both sides of this form

For ALL CTP / WORK / PUBLIC LIABILITY Related, please advise the following details:

Claim No & Insurance Company (If Known) : _____

: _____

(These details will need to be provided by you as soon as you receive them)

Please describe what you were doing when the injury occurred or the accident happened:

_____
_____
_____

Have you had any of the previous injuries of a similar nature?:

(Please list these and advise month and year of injury)

_____
_____
_____

Please list your pain and problems in order of severity:

_____
_____
_____

Patient Full Name:_____ Patient DOB:_____

Patient Signature:_____Date: _____

By Signing this form you are acknowledging all details completed are correct, and you understand that all Claim Details (If not completed) will be provided to My Family Health Medical Centre as soon as you receive them.