



NOTIFICATION FORM CLAIMS / POTENTIAL CLAIMS

Ambulatory Surgery Initiative (ASI)

This form is to be completed by the treating doctor whenever the doctor becomes aware of a Potential or Actual Claim arising out of a clinical incident during treatment of a patient.

1. Name of Hospital / Health Service _____

2. Name of the Patient _____
FAMILY GIVEN NAMES

3. Was the patient *Male* *Female*

4. Have you reported the incident to your MDO? *No*

Yes <input type="checkbox"/>	Date: _____
Name of MDO: _____	

5. What was the date of the Incident? ____ / ____ / ____

6. Have you received any correspondence from the patient, their representative or a lawyer regarding the incident? *No* *Yes*

Please attach a copy of any such correspondence to this Notification Form

What action have you taken in respect to this correspondence?

7. If you are reporting an *ACTUAL* claim please ensure the following documentation is attached:
- (any correspondence to or from the patient, their solicitors or representatives,
 - (any other relevant documents, reports, notes – including medical notes held in your private rooms.

Important Note: Please **DO NOT** copy this form or attachments to anyone else.

Doctor's Signature: _____ Date: _____

Doctor's Name: _____ Specialty: _____
FAMILY GIVEN NAMES

When complete please forward this form to the Director of Medical Services (or equivalent)