ACC 45

ACC Injury Claim Form

Patient to complete

PREVENTION. CARE. RECOVERY.
Te Kaporeihana Āwhina Hunga Whara

PART A: PERSONAL DETAILS

Family name (SURNAME)

First name(s)

Date of birth (DAY MONTH YEAR) Male ◯ Female ◯

Home/postal address (NUMBER STREET NAME)

(SUBURB) (TOWN/CITY)

Telephone **WORK** 0 (CODE) **HOME** 0 (CODE)

What is your ethnic background? *This information is collected for statistical reasons only, to help ACC develop services that are culturally appropriate.*

◯ NZ European/Pakeha ◯ Cook Island Maori ◯ Fijian ◯ Indian ◯ Samoan ◯ Other ethnic group – *please specify*
◯ Other European ◯ Tongan ◯ Other Pacific ◯ Other Asian ◯ Tokelauan
◯ NZ Maori ◯ Niuean ◯ South East Asian ◯ Chinese ◯ I'd prefer not to say

PART B: ACCIDENT AND EMPLOYMENT DETAILS

If required you can provide further information in answer to the following questions on a separate piece of paper.

When did the accident happen? (DAY MONTH YEAR) at (TIME) ◯ am ◯ pm

Accident scene *(eg. home, place of work, road)* Christchurch Public Hospital

Accident location *(eg. Taupo)* Where injury was acquired, eg. Hospital, residential facility

Did the accident occur in New Zealand? ◯ Yes ◯ No

What were you doing – what happened – how was the injury caused? *(eg. cleaning kitchen, slipped on wet floor and hit head on table)*

Details of causative factors eg. For PI patient had decreased mobility, incontinence

Did the accident involve a moving motor vehicle on a public road, driveway or beach? ◯ Yes ◯ No

If sporting injury, name sport *(eg. rugby union)*

Occupation

Please tick those Patients current occupation ◯ I own/part own the company in which I work ◯ I am self-employed ◯ I am not in paid employment

What type of work do you do? (Tick one box only) ◯ Sedentary *(brief standing and walking)* ◯ Light *(mainly standing and walking)* ◯ Medium *(often lift 5kg plus)* ◯ Heavy *(often lift 9kg plus)* ◯ Very heavy *(often lift 22kg plus)*

Did the accident occur at work? ◯ Yes ◯ No

What is the name of the business you are employed by/own?

What is the address of the business you are employed by/own?

EMPLOYER NAME AND ADDRESS

PART C: PATIENT AUTHORISATION AND DECLARATION

I have read and understood the Important Information and the Patient Authorisation and Declaration on the reverse of the patient copy of this form

Patient to sign here or legal guardian or representative ✘ Patient to sign form here

If unable then a patients delegate signs here eg. Nurse or family

Date (DAY MONTH YEAR)

Authorised representative's name RD24790

Authorised representative's relationship to patient

Treatment Provider to complete

Note: ACC does not provide cover for illness or sickness.

PART D: INJURY DIAGNOSIS AND ASSISTANCE

Patient's NHI no.

Diagnosis coding used if not READ CODES ◯ ICD9 ◯ ICD10

Diagnosis 1 Write injury in this space Side: ◯ Left ◯ Right

Diagnosis 2 Side: ◯ Left ◯ Right

Diagnosis 3 Eg. Pressure injury Side: ◯ Left ◯ Right

Is this a work related gradual process, disease or infection claim? ◯ Yes ◯ No

Additional injury comments to injury code entered above

Write any extra details about injury here, eg. *Stage 2 Pressure injury sacrum.*

Has the patient been admitted to hospital? ◯ Yes ◯ No Admitted due to injury

Is this claim for treatment injury? √ Yes ◯ No *(If Yes, also fill in ACC2152)*

Referral information *(type of Treatment Provider referred to)*

Equipment eg NPWT. roho. Services eg district nursing on discharge

REHABILITATION/ASSISTANCE REQUIRED *(eg. case management or home help)* ◯ Yes ◯ No

ACC should call me? ◯ Yes ◯ No

PART E: ABILITY TO WORK

Registered Medical Practitioner only to complete this part

IS THE PATIENT ABLE TO CONTINUE NORMAL WORK? ◯ Yes *(go to part F)* ◯ No *(continue)*

RESTRICTED DUTIES: The patient is able to undertake restricted duties

for days, from (DAY MONTH YEAR) of the following type:

◯ Sedentary *(brief standing and walking)* ◯ Light *(mainly standing and walking)* ◯ Medium *(often lift 5kg plus)* ◯ Heavy *(often lift 9kg plus)*

Additional restrictions *(eg. up to four hours per day; no lifting)*

Doctor to complete if time off work is required, otherwise leave blank if patient unemployed or retired

FULLY UNFIT: The patient is unfit for work for days, from (DAY MONTH YEAR)
(Maximum 14 days using this form)

REVIEW/RETURN TO WORK: Based on this medical assessment

◯ a review is required on, or

◯ the patient should be fit to return to normal work on: (DAY MONTH YEAR)

PART F: TREATMENT PROVIDER DECLARATION

I certify that, on the date shown, I have personally examined the patient and that in my opinion the condition is the result of an accident. I also certify that the patient (or their representative) has signed the Patient Authorisation and Declaration and has authorised me to lodge the claim on their behalf.

ACC PROVIDER NUMBER K21882

HEALTH PRACTITIONER INDEX (PERSON (CPN)) G (ORGANISATION) F (FACILITY)

Treatment provider name *(print)* or stamp Canterbury District Health Board

Treatment provider signature Staff completing form sign here Date (DAY MONTH YEAR)

ACC or Accredited Employer copy: please return this form when completed to your ACC Service Centre or to the Accredited Employer (check www.acc.co.nz).

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