



## 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**

<p>If the person is a <i>health practitioner</i>:</p> <p>I have formed the reasonable belief that the practitioner has behaved in a way that constitutes notifiable conduct as they have:</p> <ul style="list-style-type: none"><li><input type="radio"/> practised their profession while intoxicated by alcohol or drugs</li><li><input type="radio"/> engaged in sexual misconduct in connection with the practice of their profession</li><li><input type="radio"/> placed the public at risk of substantial harm in their practice of their profession because they have an impairment</li><li><input type="radio"/> 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.</li></ul>	<p>If the person is a <i>student</i>:</p> <ul style="list-style-type: none"><li><input type="radio"/> 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.</li></ul>
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### 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.

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### 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? How did the matter come to your attention?

Yes  No

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](http://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](http://www.oho.qld.gov.au).