Certificate of injury form

To be completed by health service or therapy provider

About this document

Patients who have been injured during or following a violent crime or due to modern slavery may apply for support through the NSW Government as part of the Victims Support Scheme. In most cases they must present documents to verify that they were injured due to a violent crime or modern slavery.

This certificate is intended to be used for such verification. The information is being collected for the purposes of furthering the named patient's application for financial and other support under the *Victims Rights and Support Act 2013* ("the Act"). It will be stored, used, and disclosed in accordance with the Department of Communities and Justice ("the Department") privacy policy and privacy management plan, available on the Department's website at www.dcj.nsw.gov.au. Victims Services will not cover the cost for the completion of this report.

Part A: Patient details

1. Full name _____ 2. Date of birth _____ *(dd/mm/yyyy)*

Part B: Injury* details *(*Includes psychological or psychiatric harm)*

3. Date of examination or consultation _____
4. Date patient first seen at this practice/hospital for this injury _____
5. Patient's stated date of injury _____
6. Patient's stated cause of injury ("incident"):

_____

7. Describe incident in detail as stated to you:

_____

Part C: Symptoms and diagnosis

8. Patient's presentation and presenting symptoms:

_____

9. The patient is/was suffering from
(List all diagnoses resulting from the stated cause of injury. If symptoms only, tick "Provisional diagnosis")

☐ Provisional diagnosis

_____

10. Is this consistent with your clinical findings? Yes ◯ ▶ *Go to Part D* Unclear ◯ ▶ *Go to Q.11*
11. Please provide details of inconsistency with clinical findings

_____

Part D: Aetiology

12. Is the (provisional) diagnosis consistent with the incident as described?

○ Yes ▶ *Go to Q.14* ○ Unclear ▶ *Go to Q.13*

13. Please provide details of possible inconsistency:

14. Pre-existing factors or condition aggravated by incident?

○ Yes ▶ *Go to Q.15* ○ N/A ▶ *Go to Part E*

15. List all known or disclosed pre-existing conditions that have been aggravated by this incident

Part E: Follow up

16. Further appointments made *(dates)*

17. Referrals: ☐ Diagnostic ☐ Allied Health ☐ Specialist/GP ☐ None

Name/discipline

Details *(specify)*

Part F: Medical/dental/counselling practitioner details and statement *(or use practice/hospital stamp)*

I have discussed the information contained in this certif cate with the patient. I have provided the clinical information in this certificate following appropriate investigation, and certify the content reflects my true and honest professional opinion.

Practitioner name

Email

Qualification

Practice/hospital

Phone

Postal address

Signature

Date

Affx practice/hospital stamp here