

GPs' Guide to Completing the ACC45 Injury Claim Form For a Sensitive Claim (as at July 2003)

**Parts A,B & C:
Patient Information**

Please also give previous surname if changed in the past few years.

Accurate name, address and date of birth information enables ACC to link new claims to previous claimant records.

ACC collects ethnicity data to ensure that it can provide services that are culturally appropriate.

When did the accident happen – if exact date not known, the year will be acceptable.

Please provide either Schedule 3 (see over) event number or a description of the incident/s.

Occupation information helps ACC to estimate the impact of injuries on individuals in particular occupations.

ACC needs this information even if this is not a work injury.

The employer name & address is required if the claimant needs time off work.

The form must be signed and dated before it can be accepted by ACC.

ACC 45 ACC Injury Claim Form Patient to complete

PART A: PERSONAL DETAILS

Family name: SURNAME
 First name(s):
 Date of birth: DAY MONTH YEAR Male Female
 Home/postal address: NUMBER STREET NAME TOWN/CITY
 Telephone Work: 0 XXXX XXXX Home: 0 XXXX XXXX

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 & EMPLOYMENT DETAILS

When did the accident happen? DAY MONTH YEAR at TIME am pm
 Accident scene (e.g. home, place of work, road):
 Accident location (e.g. Taupo): Did the accident occur in New Zealand? Yes No
 What were you doing – what happened – how was the injury caused? (e.g. cleaning kitchen, slipped on wet floor and hit head on table):
 Did the accident involve a moving motor vehicle on a public road, driveway or beach? Yes No If sporting injury, name sport (e.g. rugby union):
 Occupation:
 Please tick those that apply: I work part-time or full-time I own /part own the company in which I work I am self-employed I am not employed
 What type of work do you do? Sedentary (brief standing and walking) Light (mainly standing and walking) Medium (often lift 5kg plus) Heavy (often lift 5kg plus) Very Heavy (often lift 22kg plus)
 Did the accident happen 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?

PART C: PATIENT DECLARATION

I have read and understood the important Patient Information and Patient Declaration on the reverse of the patient copy of this form.
 Patient to sign here or legal guardian or representative: NAME DATE DAY MONTH YEAR
 Authorised representative's name: AUTHORIZED REPRESENTATIVE'S RELATIONSHIP TO PATIENT DATE DAY MONTH YEAR

Check if this is a safe address for ACC to write to.

ACC calls many claimants. Accurate information assists in making contact quickly.

Please tick one box

Employers pay for work claims (including claims for shareholder employees).

Self-employed people pay for work claims to the self-employed.

The government pays for claims from people who are not in employment.

Earners pay for non-work claims (e.g. home, sport) from employees, self-employed & shareholder employees.

The patient signature, in conjunction with the patient declaration on the reverse of the form, authorises the provider to lodge the claim with ACC and to release information to ACC and its agents.

Representative details must be given if signing for/on behalf of claimant.

Parts D,E & F completed by GPs

Please provide a diagnosis of the mental injury that has arisen from the Schedule 3 event. ACC requires one or more diagnosis codes using Read, ICD9 or ICD10 (please indicate which one is used) or you may write the diagnosis eg "depression".

See the address on the back of this form for Sensitive Claims.

Tick "Yes" if the patient will need further assistance from ACC such as home help or case management. Tick "No" if the patient just needs simple medical or referred treatment without other assistance from ACC.

Please consider if the patient is able to return to work on restricted duties. If so, please indicate the number of days and the nature of the restriction.

If the patient does not want the employer to see this form due to the nature of the information on it, you may certify incapacity on a separate ACC 18 medical certificate.

ACC Provider number, name, signature & date must be completed before the form can be accepted by ACC.

Treatment Provider to complete Note: ACC does not provide cover for illness or sickness. XX12345

PART D: INJURY DIAGNOSIS AND ASSISTANCE

Patient's NHI no.:
 Diagnosis coding used if not READ CODES: ICD9 ICD10
 Diagnosis 1: Side: Left Right
 Diagnosis 2: Side: Left Right
 Diagnosis 3: Side: Left Right
 Is this a Gradual Process injury? Yes No
 Additional injury comments to injury code entered above:
 Has the patient been admitted to hospital? Yes No
 Is this claim for medical misadventure? Yes No
 Referral information (type of Treatment Provider referred to):

PART E: ABILITY TO WORK Registered Medical Practitioner only to complete this part

REHABILITATION/ASSISTANCE REQUIRED (e.g. case management or home help): ACC should call me? Yes No

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 5kg plus)
 Additional restrictions (e.g. up to four hours per day, no lifting):
 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 provided the services as specified above and that in my opinion the condition is the result of an accident.

ACC PROVIDER NUMBER: PROVIDER ID FACILITY AGENCY
 National Provider Index
 Treatment provider name (print) or stamp: PROVIDER ID FACILITY AGENCY
 Treatment provider signature: 8 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).

Quote this ACC45 Claim Form number if you call ACC about this claim.

NHI Number, if known.

Tick "Yes" if you want an ACC case manager to call you about the claim.

You only use the rest of this panel if the patient is unable to continue normal work (i.e. can perform restricted duties or is fully unfit for work).

Indicate whether the next event is a return to work or a follow-up visit to review the injury.

Then give the date of that follow-up or expected return to work.

National Provider Index not yet required.