ACC 45

ACC Injury Claim Form

Patient to complete

PART A: PERSONAL DETAILS

Family name: R A N G I (SURNAME)

First name(s): A N D I

Date of birth: 0 2 (DAY) 0 2 (MONTH) 2 0 0 2 (YEAR) Male ○ Female ✓

Home/postal address: 1 2 3 (NUMBER) A R O H A N U I T E R R A C E (STREET NAME)

O T A U A (SUBURB) W A I K A T O (TOWN/CITY) 3 4 5 6

Telephone **WORK** 0 (CODE) **HOME** 0 (CODE) 2 2 0 0 0 0 0 0 0 0

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? 0 1 (DAY) 1 0 (MONTH) 2 0 2 2 (YEAR) at 1 0 3 0 (TIME) ○ am ✓ pm

Accident scene *(eg. home, place of work, road)*: HOSPITAL

Accident location *(eg. Taupo)*: HAMILTON

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)*

MATERNAL BIRTH INJURY, THIRD DEGREE TEAR DURING CHILDBIRTH

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 that apply

- ✓ I am in paid employment *(part time or full time)*
- ○ 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: ✗ Andi Rangi

Date: 0 1 (DAY) 1 0 (MONTH) 2 0 2 2 (YEAR)

Authorised representative's name:

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. N 1 2 3 4 5 6

Diagnosis coding used if not READ CODES ○ ICD9 ○ ICD10

Diagnosis 1: L 3 4 2 Side: ○ Left ○ Right

Diagnosis 2: Side: ○ Left ○ Right

Diagnosis 3: Side: ○ Left ○ Right

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

Additional injury comments to injury code entered above: MBI

Has the patient been admitted to hospital? ✓ Yes ○ No

Is this a claim for an injury caused by treatment? ○ Yes ✓ No *(If Yes, also fill in ACC2152)*

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

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 t

- ○ Sedentary *(brief standing and walking)*
- ○ Light *(mainly standing and walking)*
- ○ Heavy *(often lift 9kg plus)*

Additional restrictions *(eg. up to four hours per day; no lifting)*: CURRENTLY LIMITED MOBILITY, ING

THIS SECTION IS ONLY TO BE FILLED OUT BY DOCTORS AND NURSE PRACTITIONERS

FULLY UNFIT: The patient is unfit for work for ____ days, from ____ (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: 1 2 (DAY) 1 1 (MONTH) 2 0 2 2 (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: A C C 1 2 3

HEALTH PRACTITIONER INDEX: ____ (PERSON (CPN)) G X X N N N (ORGANISATION) F – C (FACILITY)

Treatment provider name *(print)* or stamp: H HOPATA

Treatment provider signature: ✗ [signature] Date: 0 1 (DAY) 1 0 (MONTH) 2 0 2 2 (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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