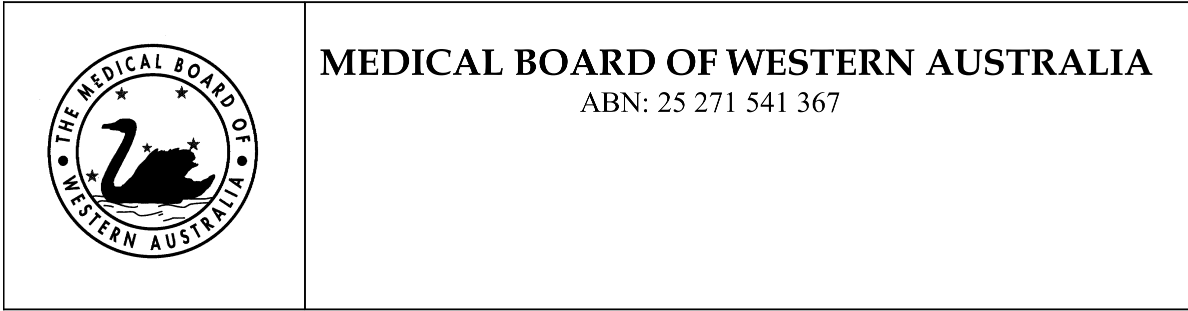

MEDICAL BOARD OF WESTERN AUSTRALIA
ABN: 25 271 541 367

NOTIFICATION FORM

1. NOTIFICATION (COMPLAINT) INFORMATION –

DETAILS OF THE PERSON WHO CONSULTED WITH/WAS TREATED BY THE MEDICAL PRACTITIONER:

Dr/Mr/Mrs/Ms/Miss (other)_____ Surname: ________________________________

Given Names: ____

Address: ____

Suburb:_____________________________ State: ___________ Postcode: ____________

Contact Phone No: Daytime contact ______________ Mobile: _______________

Male: ☐ Female: ☐

Date of Birth: __________________________

2. DETAILS OF THE PERSON MAKING THE NOTIFICATION:

Please fill out this section only if you are **not** the person who received the service but you are the person making the notification.

Dr/Mrs/Mr/Ms/Miss (other):_________ Surname:___________________________________

Given Names:____

Address: ____

Suburb_______________________________State:________________Postcode:___________

Contact Telephone Number(s):____

What is your relationship to the person who consulted with the practitioner? For example:

☐ Parent of a person under 18 years of age.

☐ Legal guardian of the person.

☐ Other (please explain the circumstances):

3. DETAILS OF THE MEDICAL PRACTITIONER YOU WISH TO REPORT:

Dr ________ First Name: ___________________ Surname______________________

Address: ____

Suburb:______________________________State _____________Postcode _____________

Telephone Number: (if you know it)____

Have you attempted to resolve the matter with the medical practitioner? ☐Yes ☐No

If yes, what attempt have you made and what was the outcome?

____

____

____

____

____

____

____

4. HAVE YOU MADE A COMPLAINT ABOUT THIS MATTER TO ANOTHER ORGANISATION?

(*e.g. Office of Health Review, Coroner etc)*

☐ No ☐ Yes

If yes, please provide the name of the organisation and an approximate date that you lodged the complaint:

____

5. MY CONCERNS ABOUT THE PRACTITIONER RELATE TO: *(tick the relevant box(es) below)*

☐ Wrong, delayed or missed diagnosis
☐ Inadequate examination or assessment
☐ Doctor's manner
☐ The examination performed by the doctor
☐ Treatment outcome
☐ Infection control
☐ Sexual Misconduct
☐ Other inappropriate conduct
☐ Medical Reports
☐ Consent
☐ Doctor refused to see patient
☐ Prescribing
☐ Medical Records
☐ Confidentiality
☐ Discrimination or bias
☐ Other:_________________________

6. Describe the Events:

Please provide a description of the events that influenced you to lodge this notification, including any relevant dates, times, locations, medical history, and if possible, any documents to support your complaint *(If there is insufficient space, please attach additional pages).*

7. **<u>By lodging this notification I am trying to:</u>** *(tick relevant box(es) below)*
Please be aware that the Board has no power to award compensation

□ Highlight to the doctor the importance of good communication

□ Make the doctor aware of my issues with the service he or she provided

□ Make the doctor aware of my concerns about what happened

□ Obtain a report from the doctor that I have not received yet

□ Receive an explanation from the doctor about my concerns

□ Receive an apology from the doctor

□ Ensure that the doctor does not do the same again

□ Other *(Please provide details):* ____

Name In Full: ____

________________________________ (Signature)

____________________ (Date)

Please complete this form, sign all relevant sections and return to:

CEO/Registrar
Medical Board of Western Australia
PO Box 1437
SUBIACO WA 6904

AUTHORISATIONS:

It would be helpful and would save time if you would provide your consent to the Board. Please complete the appropriate form and return it to the Board with your complaint.

Consent Authorisation Form — Attachment A
(Complaint is on your own behalf)

Executor/Executrix/Administrator Authorisation Form — Attachment B
(Complaint is made on behalf of a deceased person to be completed by the Executor/Executrix or Administrator of the patient's Estate)

Parent/Guardian Authorisation Form — Attachment C
(Complaint is made on behalf of your child or a child under your guardianship)

Enduring Power of Attorney Authorisation Form — Attachment D
(Complaint is made on behalf of a person for which a Power of Attorney has been appointed)

MEDICAL BOARD OF WESTERN AUSTRALIA

ABN: 25 271 541 367

Attachment A

CONSENT AUTHORISATION FORM

Our Ref: MBC/ **PRIVATE & CONFIDENTIAL**

I, ________________________________ (Date of Birth: ___/___/____) hereby consent for the Medical Board of Western Australia to :

1) access information, including my medical records, related to the complaint made by ____________________________; and
2) provide my medical records and other relevant information to the practitioner who is the subject of the complaint in order to obtain a response; and
3) provide my medical records and other relevant information to any necessary experts in order to obtain expert opinions in relation to the complaint and associated issues.

________________________________ ________________________________

(Signature) (Date)

Pamela Malcolm
CEO/Registrar
Medical Board of Western Australia
PO Box 1437
SUBIACO WA 6904

	MEDICAL BOARD OF WESTERN AUSTRALIA ABN: 25 271 541 367

Attachment B

EXECUTOR/EXECUTRIX/ADMINISTRATOR CONSENT AUTHORISATION FORM

Our Ref: MBC/ **PRIVATE & CONFIDENTIAL**

Please specify the appropriate designation

I, ______________________________ as Executor/Executrix/Administrator of the estate of ______________________ (Date of Birth: ___/___/____) hereby consent for the Medical Board of Western Australia to :

1) access information, including the medical records, of ____________________ related to the complaint made by ______________________ ; and
2) provide the medical records and other relevant information to the practitioner who is the subject of the complaint in order to obtain a response; and
3) provide the medical records and other relevant information to any necessary experts in order to obtain expert opinions in relation to the complaint and associated issues.

______________________________ (Signature)

______________________ (Date)

Please attach the relevant documentation authorising the appointment of the Executor/Executrix/Administrator and return the completed form to:

MEDICAL BOARD OF WESTERN AUSTRALIA
ABN: 25 271 541 367

Attachment C

PARENT/GUARDIAN CONSENT AUTHORISATION FORM

Our Ref: MBC/ **PRIVATE & CONFIDENTIAL**

I, as the Parent/Guardian of ____(M/F)

(Date of Birth: ___/___/___) hereby consent for the Medical Board of Western Australia to:

1) access information, including the medical records, of ______________________ related to the complaint made by __________________________; and
2) provide the medical records and other relevant information to the practitioner who is the subject of the complaint in order to obtain a response; and
3) provide the medical records and other relevant information to any necessary experts in order to obtain expert opinions in relation to the complaint and associated issues.

____________________________________ ____________________________

(Signature) (Date)

MEDICAL BOARD OF WESTERN AUSTRALIA
ABN: 25 271 541 367

Attachment D

ENDURING POWER OF ATTORNEY CONSENT AUTHORISATION FORM

Our Ref: MBC/ **PRIVATE & CONFIDENTIAL**

I, ______________________________ as the Attorney acting on behalf of

(name of person) ____________________ (M/F) (Date of Birth: ___/___/____)

hereby consent for the Medical Board of Western Australia to :

1) access information, including the medical records, of ____________________ related to the complaint made by ____________________; and
2) provide the medical records and other relevant information to the practitioner who is the subject of the complaint in order to obtain a response; and
3) provide the medical records and other relevant information to any necessary experts in order to obtain expert opinions in relation to the complaint and associated issues.

______________________________ ______________________________
(Signature) (Date)

Please attach a copy of the Enduring Power of Attorney document authorising the appointment of the Attorney and return the completed form to: