ACC 45

# ACC Injury Claim Form

*Patient to complete*

ACC — PREVENTION CARE RECOVERY
Te Kaporeihana Āwhina Hunga Whara

## PART A: PERSONAL DETAILS

Family name (SURNAME)

First name(s)

Date of birth (DAY MONTH YEAR) Mal ☐ Femal ☐

Home/postal address (NUMBER STREET NAME)

(SUBURB) (TOWN/CITY)

Telephone **WORK** O (CODE) **HOME** O (CODE)

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 sheet of paper*

When did the accident happen? (DAY MONTH YEAR) at (TIME) ☐m ☐m

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

Accident location *(eg. Taupo)*

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)*

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 DECLARATION AND CONSENT

*I have read and understood the Important Information; Patient Declaration and Consent on the reverse of the patient copy of this form.*

Patient to sign here or legal guardian or representative ✘ Date (DAY MONTH YEAR)

Authorised representative's name

Authorised representative's relationship to patient

HV93213

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*Treatment Provider to complete*

*Note: ACC does not provide cover for illness or sickness.*

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## 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 work related gradual process, disease or infection claim? ◯ Yes ◯ No

Additional injury comments to injury code entered above

Has the patient been admitted to hospital? ◯ Yes ◯ No

Is this claim for treatment injury? ◯ 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 type:

◯ Sedentary *(brief standing and walking)* ◯ Light *(mainly standing and walking)* ◯ Medium *(often lift 5kg plus)* ◯ Heavy *(often lift 9kg plus)*

Additional restrictions *(eg. 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 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 Declaration and has authorised me to lodge the claim on their behalf.*

**ACC PROVIDER NUMBER**

**HEALTH PRACTITIONER INDEX** PERSON (CPN) G ORGANISATION F FACILITY

Treatment provider name (*print*) or stamp

**Treatment provider signature** ✘ 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).**

01/2012