Latrobe Health Services Limited
ABN 94 137 187 010

Reply Paid 41, Morwell VIC 3840
Email: info@lhs.com.au
Website: latrobehealth.com.au

Member Service enquiries: 1300 362 144

Latrobe Accident Form

For completion by your treating health provider

Important information regarding accidents

An accident is defined as a sudden, unplanned and unexpected event caused by any external force resulting in acute physical injury requiring immediate treatment. An acute physical injury is defined as damage to a body part caused by a single traumatic event.

Does not include aggravation of an existing condition or injury, pregnancy, any medical conditions or injury resulting from surgical operations.

The accident must have occurred after joining, with treatment sought at an Emergency Department, Medical Practitioner or a AHPRA registered allied health provider within 14 days of accident. This form must be submitted to Latrobe within 21 days of the accident and treatment is coverable for up to 6 months from date of accident.

All treatment must be directly related to the injury sustained at the time of the accident.

CONSENT by patient for disclosure of information by health provider

The information collected on this form only relates to the accident causing an acute physical injury that requires treatment. The information will be used only for the purpose of recording the details of the accident and injury should treatment be required within 6 months of the date of the accident.

- I consent to the disclosure of my medical information, relating to the accident and acute physical injury, to Latrobe Health Services.
- I also consent for any other registered health practitioner(s) who has/have seen me regarding the condition/s to give medical information to Latrobe Health Services.
- I declare that the information stated regarding this accident and injury are correct. I understand that there are penalties for giving false or misleading information.

Signature _____ Date _____

Name _____ D.O.B. _____

Address _____ State _____ Postcode _____

Phone _____ Membership No. _____

CERTIFICATION by health provider over the page

Latrobe HEALTH SERVICES

EveryBody benefits from our health cover

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CERTIFICATION by health provider

To be lodged within 21 days of the accident

1 Date / time of accident _____

2 Details of the accident (where, what and how) _____

_____

a Mechanism of injury _____

_____

b Details of acute physical injury _____

_____

3 Date of **first** attendance for this acute physical injury _____

4 **Treatment plan** for acute physical injury:

a Immediate _____

_____

b Possible future (note: inpatient treatment is only coverable for up to 6 months from date of accident)

_____

_____

5 Did this accident occur at work? **Y** ☐ **N** ☐ Please tick one box

If **Yes**, have you lodged a claim? **Y** ☐ **N** ☐ Please tick one box

Was this a road traffic accident? **Y** ☐ **N** ☐ Please tick one box

If **Yes**, have you lodged a Transport Accident claim? **Y** ☐ **N** ☐ Please tick one box

HEALTH PROVIDER DECLARATION

I declare that the information stated regarding this accident and injuries are correct.

Signature _____ Date _____

Name _____

Address _____

State _____ Postcode _____ Phone _____