|  |  |  |
| --- | --- | --- |
| Your patient’s privacyThe TAC will treat the information requested as confidential and will use the information in this questionnaire for the purpose of determining the TAC’s liability to pay for medication for your patient.  |  | The information will not be disclosed to a third party unless this is required by law. If the TAC is not provided with this information it may affect the TAC’s ability to determine liability to fund the cost of the medication sought. |

|  |  |  |
| --- | --- | --- |
| Patient details |  |  |
| Patient name |  | Claim no. |
|       |  |       |
| Patient address |  | Date of birth |  | Date of accident |
|       |  |       |  |       |
|  Post code       |  |  |

|  |
| --- |
| Accident related injuries |
|       |
|       |
|       |
|       |

|  |
| --- |
| Current symptoms and diagnosis *attach additional notes if required* |
|       |
|       |
|       |
|       |

|  |
| --- |
| How long have you been treating this patient? |
|       |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Is the patient improving? | [ ]  | Yes | [ ]  | No | Can the TAC help by arranging a review of the patient? | [ ]  | Yes | [ ]  | No |

|  |
| --- |
| Past medical history |
| **Patient’s past non-accident medical and injury history** | **Year** |
|       |       |
|       |       |
|       |       |
|       |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Has the accident aggravated a pre-existing condition? | [ ]  | Yes | [ ]  | No |
| Please provide details of injury, original cause and extent of aggravation and treating practitioner |
|       |
|       |
|       |
|       |

Medication

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient’s current regular medication for all relevant conditions** | **Dose per day** | **Duration** | **Tick if transport accident related** |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |
|       |       |       | [ ]  Yes [ ]  No |

Provider details

|  |  |  |
| --- | --- | --- |
| Provider name, address and phone no. *Use practice stamp where possible* |  | Signature |
|  |  |  |
|  |  |  |
|  |  | HIC provider no. |
|  |  |       |
|  |  | Qualifications |
|  |  |       |
|  |  | Date |
|  |  |      /     /      |

Please attach any information that may be relevant.