# Severe Injury Advice Form

**This form is to notify Lifetime Care about a person’s severe injuries.** Providing early notification means that we can appoint a Lifetime Care contact to provide more information about applying to become an interim participant in the Lifetime Care and Support Scheme (the Scheme), under the *Motor Accidents (Lifetime Care and Support) Act 2006.*

Please provide as much information as you can. If you don’t know an answer, you can write “not known” in the box.

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| --- | --- |
| National Relay Service Callers who are deaf or have a hearing or speech impairment can call through the National Relay Service:   * TTY/voice calls: phone 133 677 and quote 1300 738 586 * Speak and Listen calls: Phone 1300 555 727 and quote 1300 738 586 | Do you need an interpreter? Please call Associated Translators and  Linguists Pty Ltd on (02) 9231 3288  between 8:30 and 5pm Monday to Friday |

## Lifetime Care

**Lifetime Care is a service line in Insurance & Care NSW (icare).** We pay for reasonable and necessary treatment, rehabilitation and care services for participants in the Scheme. You may be eligible for Lifetime Care if you are either:

|  |  |  |
| --- | --- | --- |
| An adult aged 16 years or over who has been severely injured in a motor accident in NSW from 1 October 2007 | OR | A child under 16 years who has been severely injured in a motor accident in NSW from 1 October 2006 |

AND

have sustained one of the following injuries in the motor accident:

* brain injury
* spinal cord injury
* amputation/s
* burns
* permanent blindness

### Who can complete this notification form?

* Parts 1, 2, 3 and 6 of this form are to be completed by an injured person (with support where required), or a person with parental responsibility if the injured person is a child. Where the injured person has impaired decision-making capacity or a disability that means they are unable to complete this form, written permission can be given on behalf of the injured person by a person’s representative, including a legal guardian, a person acting under an enduring power of attorney or a person responsible within the meaning of section 33A (4) of the Guardianship Act 1987, being a guardian who is appointed to given consent to carry out medical or dental treatment of the person, a spouse or partner, a carer or a close friend or relative (as defined in the Guardianship Act 1987) or a person acting under some other lawful authority.
* A person with parental responsibility or a person’s representative is referred to as a person responsible throughout this form
* A Compulsory Third Party insurer can also complete this form on behalf of an injured person under section 8 of the *Motor Accidents (Lifetime Care and Support) Act 2006* and doesn’t require the injured person’s consent to do so (however consent is recommended)
* Parts 4 and 7 need to be completed by a member of the treating health team.

### This notification form is being completed by

Injured person or person responsible (see "Who can complete this form?")

Medical/allied health professional

CTP Insurer (complete the CTP insurer details on page 5 and attach copy of claim form)

|  |
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|  |

Other:

|  |
| --- |
| Where do I send this form when it is completed? Lifetime Care  GPO Box 4052, Sydney NSW 2001 Fax: 1300 738 583 Email: Care-Requests@icare.nsw.gov.au What will happen next? We’ll appoint a Lifetime Care contact who’ll find out more about your injuries and the accident, and give you more information about the Scheme, including the eligibility criteria.  You’ll need to complete an **Interim Application Form** to apply for the Scheme and your treating team will need to assess your injury see if it meets the eligibility criteria. |

## About the information in this form

### Your privacy

Your personal and health information will be managed in accordance with the *Privacy and Personal Information Protection Act 1998* and the *Health Records and Information Privacy Act 2002*. The information collected enables Lifetime Care to administer the Scheme and carry out the functions of the Lifetime Care and Support Authority under the *Motor Accidents (Lifetime Care and Support) Act 2006*.

### Compulsory Third Party Insurance (CTP)

This form is not a CTP Personal Injury Claim Form. You may also be able to make a claim with a CTP insurer.

People whose injuries don’t meet the Scheme injury criteria may be eligible to have their treatment, rehabilitation and care expenses paid for by the CTP insurer of the vehicle that caused the injury.

Further information on making a CTP claim can be obtained by contacting the State Insurance Regulatory Authority (SIRA) CTP Assist on 1300 656 919 or email [ctpassist@sira.nsw.gov.au](mailto:ctpassist@sira.nsw.gov.au)

## Personal details of the injured person

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title | Surname | | First Name(s) | | |
|  |  | |  | | | |
| Date of Birth | | | Gender | | | |
|  | | | Male  Female | | | |
| Street Address | | Suburb | | State | Postcode | |
|  | |  | |  |  | |
| **Postal address** (if different) | | Suburb | | State | Postcode | |
|  | |  | |  |  | |
| Is an interpreter required? | | | If yes, language? | | | |
| Yes  No | | |  | | | |
| Would the injured person or their guardian like icare to consider (where possible) any cultural requirements when meeting the injured person’s treatment, rehabilitation, and care needs? | | | | | | |
| Yes  No | | | | | | |
| If yes, provide details: | | | | | | |
|  | | | | | | |

### Personal details of person responsible (see page 2, "Who can complete this form?")

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Title | Surname | | | First Name (s) | | | |
|  |  | | |  | | | | |
| Relationship to injured person | | Home phone | | | Work Phone | | | |
|  | |  | | |  | | | |
| Mobile phone | | Email address | | | | | | |
|  | |  | | | | | | |
| Street Address | | | Suburb | | | State | Postcode | |
|  | | |  | | |  |  | |
| **Postal address** (if different) | | | Suburb | | | State | Postcode | |
|  | | |  | | |  |  | |
| Is an interpreter required? | | | | If yes, language? | | | | |
| Yes  No | | | |  | | | | |
| Lifetime Care to contact: | | | | | | | | |
| Injured person  Person responsible  Other: | | | | | | | | |

## Accident details

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of accident | Time of accident | | | Street of accident | | | | Suburb of accident | | | | Postcode | |
|  |  | | | |  | | | |  | | | |  | |
| Police station | | | Event number (if known) | | | | | | | Attending officer (if known) | | | | |
|  | | |  | | | | | | |  | | | | |
| Injured person’s part in the accident: | | | | | | | | | | | | | | |
| Driver  Motorcycle rider  Pedestrian  Pillon passenger  Passenger  Cyclist  Other | | | | | | | | | | | | | | |
| **Main vehicle involved in the accident:** | | | | | | | | | | | | | | |
| Registration number plate | | State | | | | Make or model *(e.g. Toyota Camry)* | | | | | Type *(e.g. Station wagon)* | | | |
|  | |  | | | |  | | | | |  | | | |
| Was the injured person travelling in this vehicle? | | | | | | | Yes  No | | | | | | | |

## Nominated contact for treating health team

Please identify a contact person from the treating team for ongoing communication with Lifetime Care (for example a social worker, clinical nurse consultant or case manager)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Full name | | | | Position | | | |
|  | | |  | | | | | |
| Hospital or rehabilitation unit | Phone | | | | Fax | | | |
|  |  | | | |  | | | |
| Mobile phone | Email address | | | | | | | |
|  |  | | | | | | | |
| Mailing address  Street | | Suburb | | | | State | Postcode | |
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## CTP insurer notification

If a CTP insurer is completing this form, please attach a copy of the CTP claim form, any relevant accident investigation reports, police reports and any other documents.

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| --- | --- | --- | --- | --- | --- |
| CTP Insurer’s name | | CTP claim number | | | Insurer’s contact |
|  | |  | | |  |
| Phone | Email | | Postal address | | |
|  |  | |  | | |
| Claim status | | | | | |
|  | | | | | |
| Is the injured person, or their person responsible (see p1, "Who can complete this form?") aware of this notification? | | | | | |
| Yes  No | | | | | |
| Do they agree to this notification? | | | | Date CTP claim form received | |
| Yes  No | | | |  | |

## Consent and declaration

Please read carefully before signing.

**This declaration must be signed by the injured person, or a person responsible (see p1, "Who can complete this form?"). The person who signs this form must be over 18.**

**Please note a CTP Insurer cannot authorise Lifetime Care to collect and share the injured person’s personal and health information without the injured person’s consent.**

I solemnly and sincerely declare that, to the best of my knowledge, the information given in this **Severe Injury Advice Form** is true and correct in every respect.

I authorise Lifetime Care to contact, obtain and share information and documents relevant to my/the injured person’s motor accident injury and my/the injured person’s treatment, rehabilitation and care needs with:

* my/the injured person’s family or guardian
* the State Insurance Regulatory Authority (SIRA), a New South Wales government agency
* an insurer carrying on the business of providing workers compensation, personal injury or CTP insurance
* a department, agency or instrumentality of the Commonwealth, the State or another State or Territory
* if you live or travel overseas, any private or government entity necessary to deliver treatment and care services to you or otherwise manage your participation in the Scheme
* a hospital, including a private hospital
* an ambulance, police department and/or other emergency services
* a medical practitioner
* a person who is qualified to assess the treatment, care and support needs of a person
* a provider of treatment, care or support services including attendant care and support services
* an employer or previous employer
* an educational institution
* any legal practitioner engaged in representing a party making a claim for compensation or damages (including personal injury, workers compensation or CTP).

I understand that information obtained under this declaration may include pre-accident and general medical information. I understand that this information will be used for the purposes explained on page 2 of this form.

|  |  |  |
| --- | --- | --- |
| Name of injured person | Signature of injured person | Date |
|  | Signature | Click or tap to enter a date. |
| **Complete this section if you are a person responsible (see p1, "Who can complete this form?")** | | |
| Name | Signature | Date |
|  | Signature | Click or tap to enter a date. |
| Relationship to injured person | Reason why injured person could not sign | Phone/Mobile |
|  |  |  |

## Medical information

|  |
| --- |
| Name of injured person |
|  |

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| --- |
| **Brain injury**  The duration of PTA is greater than 1 week.  **OR**  There is evidence of a very significant impact to the head causing coma for longer than one hour.  **OR**  There is significant brain imaging abnormality, e.g. penetrating injury.  **AND**  The injured person is aged over 3 years and there is one FIM™ item scored 5 or less, (or 2 less than the age norm for WeeFIM®) **due to the brain injury**.  **OR**  The injured person is a child under 3 years. The child will probably have permanent impairment **due to the brain injury** resulting in a significant adverse impact on their normal development. |

|  |  |
| --- | --- |
| **Spinal cord injury**  (permanent sensory deficit, motor deficit and/or bladder/bowel dysfunction) | |
| **Neurological (SCI) level:** | **ASIA impairment scale:** |

|  |
| --- |
| **Amputation/s**  Multiple amputations (or equivalent impairment)  Multiple amputations (or the equivalent impairment) of the upper and/or lower extremities  **OR**  Unilateral amputation (or equivalent impairment)  The amputation (or equivalent impairment) is one of the following:  forequarter amputation (complete amputation of the humerus, scapula and clavicle) or shoulder disarticulation  hindquarter amputation (hemipelvectomy by trans-section at sacroiliac joint, or partial pelvectomy)  hip disarticulation (complete amputation of the femur)  short transfemoral amputation  brachial plexus avulsion or rupture resulting in partial or total paralysis  an equivalent impairment to any of the injuries described above |

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| Name of injured person |
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| **Burns**  The injured person is a child under 16 years that has full thickness burns greater than 30% of body, or full thickness burns to the hand, face or genital area, or inhalation burns causing long term respiratory impairment.  **OR**  The injured person is an adult that has full thickness burns greater than 40% of body, or full thickness burns to the hand, face or genital area, or inhalation burns causing long term respiratory impairment.  **AND**  The injured person is aged over 3 years and there is one FIM™ item scored 5 or less, (or 2 less than the age norm for WeeFIM®) **due to the burns**.  **OR**  The injured person is a child under 3 years. The child will probably have permanent impairment **due to the burns** resulting in a significant adverse impact on their normal development. |

|  |
| --- |
| **Blindness**  The injured person has sustained permanent blindness and is legally blind |

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| --- | --- | --- | --- |
| Additional comments | | | |
|  | | | |
| Treating doctor’s name | | Contact phone | |
|  | |  | |
| Qualification | Provider Number | | Date |
|  |  | |  |

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| --- |
| For more information or queries about this notification form: Contact Lifetime Care on 1300 738 586 or visit [www.icare.nsw.gov.au](http://www.icare.nsw.gov.au) |