

Medical Malpractice Consultation Form

Date: ____/____/____
Day Month Year

1. Information about you

Name

Occupation Age

Address

Telephone Number E-mail Address

2. Information about the Patient

It is you.

It is not you.

Name Occupation

Date of Birth ____/____/____ Sex Male/Female
Day Month Year

Relationship between you and the patient

3. Information about the Hospital/Clinic

Name

Address

Which Department?

(e.g. Internal Medicine, Surgery, Orthopedics, etc.)

Name of the Doctor who treated you/the patient

4. Time of Treatment

Date of first treatment / /
Day Month Year

If hospitalized, when? From / /
Day Month Year

To / /
Day Month Year

Date of last treatment / /
Day Month Year

5. The reason(s) the patient was treated by this doctor at this hospital
(e.g. Type of injury or illness, symptoms, recommendation from someone, etc.)

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.....

6. Damage

Disability What kind of disability?

When did it happened? / /
Day Month Year

Death What is the cause of death? / /
Day Month Year

Other damages Please specify.

7. Available Data

- Copies of Medical Records Copies of invoice to the Medical Insurance Insurer
- Diagnosis Death Certificate Test Result
- Images/Photographs C.T., M.R.I., X-r a y..... Autopsy Report
- Maternity Diary Member Card Receipts Diary
- Others

8. Significant events

Please write significant events, such as symptoms, diagnosis, tests, treatment, prescription, and operation) in chronological order.

Date	Event

9. Other Information

(1) How did you pay the medical fees?

- The patient paid them from my/his/her own pocket.
- The patient’s insurance company paid them.

Name of Insurer

(2) Have you/the patient ever had any major health problems or surgery?

No.

Yes.

(3) What do you think was the cause of the problem/damages and why do you think so?

.....
.....
.....

(4) Have you/the patient ever discussed with the doctor or the hospital about this problem?

No.

Yes. When? / /
Day Month Year

(5) What did the doctor or the hospital explain to you/the patient about this problem?

.....
.....
.....

(6) Did you/the patient receive any treatment and/or opinion from other doctors/hospitals about this problem?

No.

Yes. Name of the doctor/hospital
Explanation/Treatment

(7) Have you/the patient consulted anyone regarding this problem before?

No.

Yes. Name of Consultant
Advice given

(8) Questions

If you have any questions, please write them here.

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