CLIENT MEDICAL MALPRACTICE/WRONGFUL DEATH INTAKE SHEET

CALLER INFORMATION

Caller Name:_____ Relationship:_____
Home :_____ Work:_____ Cell: _____
Email:_____
Preferred Method of Contact:_____

INJURED PARTY'S INFORMATION

Injured Party's Name:_____
DOB:_____ Married:_____ Spouse Name: _____
○ Minor ○ Disabled ○ Deceased Date of Death:_____
Address:_____
City:_____ State:_____ Zip_____
Home :_____ Work:_____ Cell: _____
Email:_____
Preferred Method of Contact:_____
Name/number of someone who will be able to reach you:_____

MEDICAL NEGLIGENT INFORMATION

What injuries were sustained:_____
Date of suspected negligence:_____
What do you claim a doctor/provider did or did not do to cause an injury:_____
_____
_____
Who is the claim against:_____
What date were symptoms first noticed: _____
Did the injury require additional surgery:_____
Where:_____ Surgeon:_____ Date:_____
Any follow up treatment (dates and locations and treatment provided):_____
_____
_____
_____
_____
_____
_____
Current health status/treatment/permanency of injuries sustained:_____
_____
_____
Caller/Injured in possession of medical records?:_____
_____
Subsequent treating doctor's comments:_____

Did a treating doctor recommend any treatment that the injured declined? If so, what was recommended and why was it declined?_____

CALLER/INJURED INFORMATION

Injured's health prior to injury, to include any and all illnesses and conditions the injured had prior to claimed negligence:_____

Injury occurred during routine, elective, emergency medical treatment?:_____

Did the injured miss time from work?_____
How long?:_____ Job:_____
SSDI:_____ Reason (mental or physical):_____
Disability Award related to this incident?:_____

IF DECEASED

Date of Death:_____ Place of Death:_____
Copy of Death Certificate:_____ Cause listed on Death Certificate:_____

Autopsy performed:_____ Where:_____
Copy of Autopsy Report:_____
Does Death Certificate state that the Autopsy report was available before cause of death was determined:_____
Was an estate opened:_____ PR:_____
Does Caller have a Letter of Administration:_____
Names and ages of all surviving children:_____

Prior Medical History:

- ☐ Diabetes
- ☐ Hypertension
- ☐ Vascular Disease/vein grafting/
- ☐ Heart disease/stents/open heart surgery/
- ☐ Stroke
- ☐ Hernia
- ☐ Ob/Gyn Operations
- ☐ Amputations
- ☐ Seizures
- ☐ Head Injuries
- ☐ Broken Bones
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Eye Injury/operations/
- ☐ Bladder problems / Bladder Sling
- ☐ Gastric Bypass Surgery
- ☐ Colonoscopy
- ☐ Cancer
- ☐ Hepatitis / Any autoimmune disease/
- ☐ Gall Bladder disease/surgery
- ☐ Appendicitis
- ☐ Sepsis
- ☐ Dementia
- ☐ Pancreatitis
- ☐ Fibromyalgia
- ☐ Any mental health care/psychologist/psychiatrist
- ☐ C.O.P.D.
- ☐ Transplant surgery

Other operations:

Health Insurance:

Medicare:
Medicaid:
Federal Employee Insurance:
Tri Care:

Gall Bladder Cases:

Name of surgeon:
Location of Operation:
Date of operation:
Was the operation done on an urgent basis?
Type: Laparoscopic vs. Open?
Was a laparoscopic operation converted to an open procedure?
What was the injury?: clipped duct/cut duct/leaking duct/punctured liver/punctured bowel.
Was client released from Hospital before injury was recognized?
Return visit?
Any phone calls to surgeon following initial operation?
Any calls to PCP?

1. Prior visits to Hospital with similar complaints:
2. Prior ERCP:
3. Prior Ultrasound
4. Subsequent ERCP: date/number/hospital/doctor/
5. Subsequent stents: date/number/hospital/doctor/
6. Tube Placement/exchange/removal
7. Jaundice?
8. Subsequent surgery/Exploratory Operations/Roux En Y:
9. Bowel Damage/
10. Liver Damage/
11. Infection
12. Total number of days as an inpatient:
13. Employed/ missed time from work.
14. On disability? For what condition?
15. Photos of incision
16. Pharmacy where he/she had prescriptions filled.
17. Any follow--up care scheduled/ next appointment with doctor
18. Statements by surgeon/ when / where / to whom/ what was said/:

ADDITIONAL NOTES OR COMMENTS

GUARDIAN/REPRESENTATIVE INFORMATION

(If applicable (i.e.: death, minor, disabled))

Guardian:_____ Relationship:_____
Address:_____
City:_____ State:_____ Zip_____
Home:_____ Work:_____ Cell: _____
Email:_____
Preferred Method of Contact:_____

INTAKE INFORMATION

Intake completed by:_____ Date:_____
Reviewed by attorney:_____ Date:_____
○ Decline ○ Accept ○ Refer Out ○ Will Review Records ○ Opened in TM

FOR FIRM USE

How were you referred to our firm:_____
Have you consulted with another attorney:_____
Attorney Name & Date of Consult:_____