

<b>NF03</b>	<p><b>Notification Form</b></p> <p><b>Serious Injury to a Recipient<sup>1</sup></b></p> <p>To be completed in conjunction with  <b>'The Guide to Monitoring IPAS'</b> document available at  <a href="http://www.higa.ie">www.higa.ie</a></p>	 <p><b>Health Information and Quality Authority</b>  An tÚdarás Um Fhaisnéis agus Cálíocht Sláinte</p>
-------------	---	---

**Section 1. IPAS centre details**

Centre name	
Centre ID (OSV)	

**Section 2. Recipient's details**

Recipient's unique identifier	
Is this recipient under the age of 18?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Describe the current **status of the recipient**, such as physical or mental state:

**Section 2. Recipient's details**

<sup>1</sup> A serious injury means an injury which creates substantial risk of death or which causes serious disfigurement or substantial loss or impairment of the mobility of the body as a whole or of the function of any particular bodily member or organ.

Has an NF03 form been submitted for this person in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If <b>yes</b> , how many NF03 forms have been previously submitted?	

<b>Section 3. Injury details</b>			
<b>Date</b> of injury		<b>Time</b> of injury	
<b>Describe</b> the recipient's injury, including where on the body the injury is:			

### Section 3. Injury details

**How** did the injury happen?

Please tick the relevant box or boxes

Fall

Fire

Alleged assault

Other

If you have ticked **other** please provide details:

Did this injury occur **in the centre**?

Yes  No

## Section 4. Circumstances of the injury

What was the **intent** of the injury?

Accidental or unintended

Self-harm

Alleged assault

Other

If you have ticked **other** please provide details:

## Section 4. Circumstances of the injury

Please describe the **circumstances** that led to the injury:

## Section 5. Medical or hospital treatment

What **immediate action** was taken following the injury?

What **treatment** has the recipient received?

Please tick the relevant box or boxes

Medical treatment

Hospital treatment

Please provide detail of the **treatment** that was required:

## Section 6. Declaration

I, the undersigned, declare that the information I have provided in this notification form is true to the best of my knowledge and belief.

Name	
Job title	
Signature	
	<b>Type your name in the signature field</b>
Date	
Contact number (during office hours)	

Please return the completed, signed form by email to [ipasmonitoring@hiqa.ie](mailto:ipasmonitoring@hiqa.ie)  
Please ensure **NF03 is clearly stated in the subject bar of the email**