## Basic Details

|  |  |
| --- | --- |
| **Clinical Case Report Title** |  |
| **Author/s** |  |
| **Department & Site**  |  |
| **Contact Person**  |  |
| **Contact Email Address** |  |
| **Contact Phone Number**  |  |
| **Are all authors involved responsible for the care of the patient(s) listed in this application?** | [ ]  Yes [ ]  No*If No, have you obtained the treating physicians consent to review the patient records?*[ ]  *Yes* [ ]  *No* |

## Clinical Case Report Details

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| --- |
| **Brief Description of the case report (no more than 200 words)** |
|  |
| **Number of cases**  |  |
| **Will the information be published in identifiable or non-identifiable format?** | [ ]  Identifiable [ ]  Non-Identifiable  |
| **Please confirm that consent will be obtained** | [ ]  I confirm that Consent will be sought from all participants using a recommended template. |
| **Where do you intend to publish / present?**  |  |
| **Please select all** **options applicable to your case report** | [ ]  Medical Records Reviews[ ]  Imaging File Review [ ]  Local Departmental Records Department Name: Click here to enter text.[ ]  Local DatabaseDatabase Name: Click here to enter text.Database Custodian: Click here to enter text. |

## Declaration

[ ]  I confirm that the information contained within this application is true and accurate.

|  |  |
| --- | --- |
| **Name of Person Submitting the Application**  |  |
| **Date**  |  |