## 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

|  |  |
| --- | --- |
| **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 Database  Database 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** |  |