
LAW OFFICES OF
CRAIG GOLDENFARB, P.A.
IKON BUILDING
2090 PALM BEACH LAKES BOULEVARD, SUITE 402
WEST PALM BEACH, FLORIDA 33409

TELEPHONE 561-697-4440 TOLL FREE 1-877-21-INJURY FACSMILE 561-687-1950
WWW.PROTECTINGTHEINJURED.COM

PHONE INTAKE QUESTIONNAIRE – NURSING HOME OR MEDICAL MALPRACTICE

(last updated 7/04 by RTW)

Date: _____ Name of Person doing Intake: -

Name of caller: _____ Relationship of caller to Injured:

Address of Caller: _____

Phone Numbers of caller: Home: _____
Work: _____
Cell: _____

Date of Birth of Injured Party: _____

Who referred you to us?

___ T.V. ___ Yellow Pages ___ T.V & Yellow Pages
___ Person or Lawyer/ Their Phone # _____

Full Names (incl. **First Name**) & **SPECIALTIES** of doctors(s) or hospital(s) that you want to sue:
Defendant 1) _____ Defendant 2) _____ Defendant 3)

What are these doctor(s)/hospital(s) addresses and phone #s? (*at least name city they are in*)

Exact date of alleged malpractice: _____ (Note: S.O.L. is 2 years from when Plaintiff knew, or should have known, that malpractice occurred)

Description of alleged malpractice:

Did RISK MANAGEMENT from the facility or Dr.'s Office contact you or anyone on your behalf **in any way?** (phone, letter) ____ YES ____ NO

If Yes, Describe:

Did you, or anyone on your behalf, contact RISK MANAGEMENT? ____ Yes ____ No

Do you have an Incident Report? ____ Yes ____ No

Anyone tell you the doctor/hospital you want to sue did something wrong? ____ Yes ____ No

If Yes, Who? _____ Is it in Writing? _____

Describe what they told you:

What ADDITIONAL injuries are you suffering from as a result of the alleged malpractice?

Do you have medical records from the doctor/hospital you're looking to sue **OR** from any of your subsequent treating doctors ____ YES ____ NO

If YES, please list:

Have you reported this incident to any of the Defendants, the Agency for Health Care Administration or the Florida Dept. of Health? ____ Yes ____ No

If Yes, Who?

What other lawyers have you already called (or been represented by) for this matter?

Names: _____

Why turned down/ not representing you?

PLEASE BRING WITH YOU (TO YOUR INITIAL APPOINTMENT): **(ASK CLIENT TO WRITE THIS DOWN)**

1) Driver's License & Social Security Card; 2) Health Insurance Cards, including Medicaid/Medicare; 3) Photos of your injuries, if applicable; 4) Names/phone #s of doctors/ hospitals you have already seen as a result of the medical error you claim occurred. 5) ANY MED. RECORDS YOU HAVE (related to this matter); 6) Letters from Lawyers that turned you down, if any; 7) Incident Report, if any

Results of Call: _____ Turndown _____ Appt. Sched. For _____

Physician We Referred To: _____

Attorney We referred to: _____

Other result of call: (please explain) _____