



BPS Healthcare Ltd

Bringing Innovation to Healthcare Solutions

Patient Advocacy Service Questionnaire

Personal Information

Name _____

Sex M/F (please circle)

Date of birth _ _ / _ _ / _ _ _ _

Contact details (include telephone no)

Do you believe you suffered clinical negligence?

YES / NO (Please circle)

Kindly tick the box that corresponds to your reason(s) for wanting to make a claim:

Reason(s)/the liability

- You were given a wrong diagnosis
 - A mistake was made during a procedure/operation
 - You were given the wrong drug
 - Your consent was not sought before the treatment/procedure
 - You were not warned about the risks/side-effects of a treatment
 - Any other reason
- _____

Did this cause you any direct injury (physical, emotional, psychological)?

YES / NO (Please circle)

Kindly tick the box that corresponds to the injury you sustained

Injuries/the causation

- Physical injuries/disability
 - Emotional and Psychological injury (mental suffering such as prolonged shock horror, panic, sleeplessness, depression, change in behaviour etc)
 - Any other injuries
- _____

PLEASE RETURN THIS FORM COMPLETED TO:

BPS Healthcare Ltd.
Suite 8A Tafawa Balewa Square, Lagos Island, Lagos, Nigeria