CBHS HEALTH

CBHS Health Fund Limited ABN 87 087 648 717

Please send this Certificate and any additional information to:
By Post: CBHS Health Fund Limited
Locked Bag 5014, Parramatta NSW 2124
Fax: 02 9843 7677
Member Care Centre: 1300 654 123

Certificate for Medical Practitioner

SECTION 1 – Patient's details

1. **In relation to** Patient's name

   Member number

2. **Problems** (A copy of the patient's authority to release this information is attached)

SECTION 2 – Medical Practitioner's details

3. **Contact details** Doctor's Stamp **OR** Doctor's name

   Address

   State Postcode

   Telephone

SECTION 3 – Treatment details

4. **When did the patient first consult with you about the matters related to the problem/s mentioned above?** D D / M M / Y Y Y Y

5. **What was he/she then suffering from?**

6. **Please give a brief medical history of matters related to the problem/s mentioned above with particular mention of the date of onset of signs and/or symptoms and the treatment recommended or carried out.**

   When the patient first consulted you for the problem/s mentioned above, related signs and/or symptoms had been present for (please be as specific as possible)

   hours days weeks months years

   Related history

   Please state if the procedure was for a medical or cosmetic reason Medical Cosmetic

   If this is an obstetric case please state the expected date of confinement D D / M M / Y Y Y Y

   The patient was referred to Dr/Mr on D D / M M / Y Y Y Y

   Telephone

   If the patient has been referred to you please supply the following

   The patient was referred by Dr/Mr on D D / M M / Y Y Y Y

   Telephone

Medical Practitioner's signature

D D / M M / Y Y Y Y

The CBHS Health Fund Limited thanks you for taking the time to fill in this form.