CBHS Health Fund Limited
ABN 87 087 648 717

Certificate for Medical Practitioner

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)**

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

Medical Practitioner's details

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

Address

State Postcode

Telephone ( )

Treatment details

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

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 / /

The patient was referred to Dr/Mr on / /

Telephone ( )

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

The patient was referred by Dr/Mr on / /

Telephone ( )

Medical Practitioner's signature

/ /

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