CBHS

Health Cover for the CommBank Family

Please send this form and any additional information:
By Post: CBHS Health Fund Limited
Locked Bag 5014, Parramatta NSW 2124
Fax: 02 9843 7676 **Email:** pec@cbhs.com.au

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?** / /

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

✗

Date / /

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