

HCF Membership No.

Complete and email to:
clinicalreviewemail@hcf.com.au

1 Member to complete

+

To Dr

I hereby authorise you to complete the Certificate of Attendant below and to provide any further information required by HCF in regard to the condition requiring hospitalisation.

Member's name

Member's
Signature

X

(DD MM YYYY)

If you would like to receive a response to this request via email, please insert your email address.

2 Doctor to complete

Are you the above member's regular General Practitioner? Yes No If yes, for how long?

I hereby certify that

Date of birth (DD MM YYYY)

was suffering from

He/she first consulted me on (DD MM YYYY) for the above condition which has required/will require hospitalisation.

The symptoms of this condition were present for a period of hours days months years prior to the first consultation.

Brief history of this condition including date/s of onset of signs/symptoms

The following surgery is required

CMBS item number

Patient was **referred by** myself/Dr

Expected date of hospitalisation (DD MM YYYY)

Patient was **referred to** myself/Dr

Date of specialist's referral (DD MM YYYY)

Doctor's
Signature

X

Date (DD MM YYYY)

Provider number

Name

Address

State

Postcode

Business number

3 In obstetric and birth related cases

Date of last menstrual period (DD MM YYYY) Expected date of confinement (DD MM YYYY)

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