CBHS CORPORATE

CBHS Corporate Health Pty Ltd ACN 85 609 980 896

Please send this Certificate and any additional information to:
Email: help@cbhscorp.com.au
Post: CBHS Corporate, Locked Bag 5098, Parramatta, NSW 2124
Fax: 02 8604 3576 **Phone:** 1300 586 462

Certificate for Medical Practitioner

PATIENT DETAILS

1. In relation to Patient's name

Member number

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

MEDICAL PRACTITIONER'S DETAILS

1. Contact details Doctor's Stamp

OR

Doctor's name

Address

State Postcode

Phone: ( )

TREATMENT DETAILS

1. Please give a brief medical history of matters related to the condition/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 condition/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 on / /

Contact number: ( )

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

The patient was referred by Dr on / /

Contact number: ( )

MEDICAL PRACTIONER'S SIGNATURE

Signature ✗ Date signed / /

CBHS Corporate Health thanks you for taking the time to fill in this form