CBHS GROUP

Please send this certificate and any additional information
By Post: CBHS Group
Locked Bag 5014, Parramatta NSW 2124
Email: pec@cbhs.com.au

Pre-existing condition form

SECTION 1: Patient's details

1. Patient's name

Member number

SECTION 2: Medical practitioner's details

2. Contact details

Doctor's stamp

OR

Doctor's name

Address

State Postcode

Telephone

SECTION 3: Treatment details (Doctor to complete)

3. When did the patient first consult with you about the matters related to the condition?

Date D D / M M / Y Y Y Y

4. What were they then suffering from?

5. Please give a brief medical history of matters related to the problem/s as noted 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 as noted above, how long had the related signs and/or symptoms 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 Date D D / M M / Y Y Y Y

The patient was referred to Dr/Mr/Mrs/Miss/Ms 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/Mrs/Miss/Ms D D / M M / Y Y Y Y

Telephone

Medical practitioner's signature

✗

Date / /

SECTION 4: Authorisation (Member to complete)

6. I, **patient/authorising person's name** consent to the disclosure of my medical information relating to the condition/s requiring hospital treatment to CBHS Health Fund. I also give consent for any other medical practitioner(s) who has/have seen me regarding the condition/s to give medical information to the health fund.

7. If the patient is under the age of 18 years the authorising member should sign.

✗

Date / /