

**INSTRUCTIONS FOR COMPLETING FORM** Please use a black pen and print in CAPITALS.

1. Please print your name and membership number and sign the authority prior to forwarding to your doctor.
2. The doctor you first consulted with this condition will need to complete this certificate.
3. Another form may also need to be filled out by your specialist doctor.
4. Please fax this certificate for prompt processing.

**Authority (to be completed by patient or patient's legal guardian)**

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.

HCF Membership Number:

Member's Name:

Member's signature:

Date:

**Certificate of Attendant (to be completed by the doctor consulted for the condition treated)**

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

I hereby certify that

Date of birth

was suffering from

He/she first consulted me on  /  /  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:

Patient was referred to myself/Dr:

Date of specialist's referral:

Doctor's signature:

Date:

Provider Number:

Name:

Address:

State:

Postcode:

Business Number:

**In obstetric and birth related cases please state**

Date of last menstrual period

Expected date of confinement