HCF Certificate of Attendant

HCF Membership No.

Complete and fax to:
02 9248 9423

or 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)

How HCF collects, uses, discloses (which may include obligations to overseas recipients in compliance with its privacy obligations) and keeps and secures personal information including how to opt out from direct marketing, how to request access to and correction of your personal information or how to complain about a privacy breach and how this is handled by HCF is explained in the HCF privacy policy. For a copy of this policy, call our member services team on 13 13 34 or go to hcf.com.au.