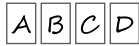


# MEDICAL PRACTITIONER CERTIFICATE - GENERAL PRACTITIONER

Please use black pen and print upper case.  
Avoid contact with the edge of the box.



## Consent by patient for release of information

The information collected on this form only relates to the condition/s requiring hospitalisation at this time. The information will be used only for the purpose of determining whether the condition/s requiring hospitalisation is/are pre-existing.

I consent to the disclosure of my medical information relating to the condition(s) requiring hospital treatment to AIA Health Insurance. I also give consent for any other practitioner(s) who has/have seen me regarding the condition(s) to give medical information to the health fund.

Member name	Membership number
<input type="text"/>	<input type="text"/>
Address	
<input type="text"/>	
Suburb	State Postcode
<input type="text"/>	<input type="text"/> <input type="text"/>
Phone	Date of birth
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Signature	Date
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

## Certification by General Practitioner

Patient name	1. DATE of HOSPITAL admission (or proposed admission)
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> to <input type="text"/> / <input type="text"/> / <input type="text"/>
2. a. Principal condition	2. b. Nature of operation (if any)
<input type="text"/>	<input type="text"/>
2. c. Associated conditions (if any)	3. Date of patient's FIRST attendance for this illness
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
4. Signs or symptoms of the condition (i.e. in 2a above) when first seen	
a. consisted of	<input type="text"/>
b. had commenced on	<input type="text"/> / <input type="text"/> / <input type="text"/>
c. had been present for	<input type="text"/> days / <input type="text"/> weeks / <input type="text"/> months / <input type="text"/> years

5. Are you the patient's usual general practitioner? (please tick)

Yes  No

If YES – Did you refer the patient to a specialist? (please tick)

Yes  No

If YES – To whom? Name of specialist

Date of referral

Address of specialist

### General Practitioner's signature

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General Practitioner

Phone

Address

Signature

Date

Please return your completed and signed form to AIA Health via email: [corporatehealth.claims@aia.com.au](mailto:corporatehealth.claims@aia.com.au)  
or post: AIA Health, PO Box 7302, Melbourne VIC 3004