HEALTHIER, LONGER, BETTER LIVES

MEDICAL PRACTITIONER CERTIFICATE – GENERAL PRACTITIONER

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

A B C D

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

Address

Suburb

State

Postcode

Phone

Date of birth

Signature

Date

Certification by General Practitioner

Patient name

1. DATE of HOSPITAL admission (or proposed admission)

to

2. a. Principal condition

2. b. Nature of operation (if any)

2. c. Associated conditions (if any)

3. Date of patient's FIRST attendance for this illness

4. Signs or symptoms of the condition (i.e. in 2a above) when first seen

a. consisted of

b. had commenced on

c. had been present for days / weeks / months / years

Continued on next page

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

General Practitioner

Phone

Address

Signature

Date
☐☐/☐☐/☐☐☐☐

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