Latrobe HEALTH SERVICES
EveryBody benefits from our health cover

Latrobe Health Services Limited
ABN 94 137 187 010
Reply Paid 41, Morwell VIC 3840
Email: info@lhs.com.au
Website: latrobehealth.com.au
Member Service enquiries: 1300 362 144

Medical Practitioner Certificate

For your general practitioner

Regarding pre-existing ailments

Under the National Health Act 1953, a pre-existing ailment is an ailment, illness or condition, the signs and/or symptoms of which in the opinion of a medical practitioner appointed by the health fund, existed at any time during the 6 months preceding the day on which the contributor (patient) began contributions to their current hospital table.

This form requests information from you about signs and/or symptoms associated with the condition/s requiring hospital treatment. The medical practitioner appointed by Latrobe will use the information to make an informed PEA assessment and allow Latrobe to determine the level of health insurance benefits to which the patient is entitled. Latrobe may disclose the information to the patient as part of the evidence considered in this matter. The patient may disclose the information to the Private Health Insurance Ombudsman in the event of a complaint arising from this matter.

CONSENT by patient for disclosure of information by doctor to health fund

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 Latrobe Health Services.

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.

Signature _____ Date _____

Name _____ D.O.B. _____

Address _____ State _____ Postcode _____

Phone _____ Membership No. _____

CERTIFICATION by medical practitioner over the page

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CERTIFICATION by medical practitioner

1 Date of hospital admission (or proposed admission) _____ to _____

2 a Principal condition (reason for hospitalisation) _____

_____

b Nature of operation (if any) _____

_____

c Associated conditions (if any) _____

_____

3 Date of patient's **first** attendance for this illness _____

4 **Signs** or **symptoms** of the condition (ie in 2a. as above) when first seen:

a Consisted of _____

_____

b had commenced on _____

c has been present for _____ days _____ weeks _____ months _____ years

5 Are you the patient's usual general practitioner? Y ☐ N ☐ Please tick one box

If **Yes**, did you refer the patient to a specialist? Y ☐ N ☐ Please tick one box

If **Yes**, to whom?

Name of specialist _____

Date of referral _____ Phone _____

Address of specialist _____

Signature _____ Date _____

Name _____

Address _____

State _____ Postcode _____ Phone _____

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_____

b had commenced on _____

c has been present for _____ days _____ weeks _____ months _____ years _____

5 Are you a specialist by whom the patient was treated? Y ☐ N ☐ Please tick one box

If **Yes**, who referred the patient to you?

Name of referring practitioner _____

Date of referral _____ Phone _____

Address of practitioner _____

Signature _____ Date _____

Name _____

Address _____

State _____ Postcode _____ Phone _____