Medical Practitioner Certificate regarding 'Pre-Existing Conditions'

A Pre-Existing Condition means an ailment, illness or condition that, in the opinion of a medical practitioner appointed by Westfund, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the policy. This certificate is to assist in determining the level of health insurance benefits which will apply when hospitalisation is required for a member of less than twelve months on their current level of cover.

Consent by Patient for release of information

Patient

Membership Number: _____

Patient's Full Name: _____ Date of Birth: ___/___/___ (Day Month Year)

Patient's Home Address: _____

Patient's Home Phone: ( ) _____ Mobile: _____

I consent to the release of my medical information to the medical advisor of Westfund in respect of the condition outlined below.

Signature of Patient

or Parent/Guardian: _____ Date: ___/___/___ (Day Month Year)

Certification by Medical Practitioner

Medical Practitioner

Date of Hospital Admission: ___/___/___ (Day Month Year) to ___/___/___ (Day Month Year)

Principal condition (reason for hospitalisation): _____

Associate conditions (if any): _____

Date of patient's first attendance for this condition: ___/___/___ (Day Month Year)

Signs and symptoms of condition when first seen:

a) consisted of _____

b) had commenced on ___/___/___ (Day Month Year)

c) had been present for _____ days _____ weeks _____ months _____ years _____

Are you the patient's usual General Practitioner? Yes ☐ No ☐

Did you refer the patient to a Specialist? Yes ☐ No ☐ If yes please fill in section 1

Are you a Specialist by whom the patient was treated? Yes ☐ No ☐ If yes please fill in section 2

Section 1

Referring Practitioner's details

Date of Referral: ___/___/___ (Day Month Year)

Name of Referring Practitioner: _____ Phone: ( ) _____

Address of Referring Practitioner: _____

Referring Practitioner's Signature: _____ Date: ___/___/___ (Day Month Year)

Section 2

Specialist's details

Date of Referral: ___/___/___ (Day Month Year)

Name of Specialist: _____ Phone: ( ) _____

Address of Specialist: _____

Specialist's Signature: _____ Date: ___/___/___ (Day Month Year)

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