



Looking After Life since 1847
A Member of the Guardian Holdings Group

PRE – CERTIFICATION FORM

Patient: _____ Age: _____ D.O.B: _____

Referred by :- (G.P.) _____ Date of referral: _____

Referred to (Specialist): _____

Specialist/ Report: _____

Medical History & Finding: _____

Diagnosis: _____

Treatment/ Procedure Recommended by Psychiatrist:

Estimated Cost:

Proposed Date of Treatment: _____

Any other information: _____

PLEASE INDICATE COPIES TO BE SENT TO:

SURGEON/SPECIALIST :

HOSPITAL:

INSURED/PATIENT:

Psychiatrist/Representative Signature/Stamp

Date

Insured/Patient's Signature

Date

NOTE: Treatment must be completed within 30 days from the date of this authorisation