



Hurstville & Rockdale Friendly Society Limited

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CHRONIC MEDICAL CONDITIONS ASSESSMENT FORM

Hurstville and Rockdale Friendly Society aims to assist its members with the financial burden of living with chronic medical conditions. Completing this form will assist the Society in providing support for members and any information will be treated as strictly confidential.

PART A: MEMBER TO COMPLETE

NAME: _____ D.O.B. _____

ADDRESS: _____

Types of costs incurred in living with the chronic condition(s): **NOT INCLUDING OUT OF POCKET MEDICAL EXPENSES**

Approximate cost per month: _____ Date: _____

PART B: REGISTERED MEDICAL PRACTITIONER TO COMPLETE

NAME: _____ LENGTH OF TIME TREATING MEMBER: _____

ADDRESS: _____

1. Chronic medical conditions that have persisted for more than 6 months:

2. How does it affect the quality of life for this person:

Medical Practitioner signature: _____ Date: _____

OFFICE USE ONLY:

Assistance per year: _____ Approved Amount: _____ Signature: _____

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