

MEDICAL HISTORY TRANSFER REQUEST

Date:

To: Doctor / Clinic:

Address:

.....

.....

Re:

Patient Name:

Patient Address:

.....

.....

Patient D.O.B.:

Additional family members requesting transfer of history:

..... D.O.B.

..... D.O.B.

..... D.O.B.

The above named patient/s have elected to attend Surrey Street Family Clinic for future medical care.

As we are a paperless clinic, please forward a copy of the patient's complete medical history, including correspondence, investigations and consultation records in electronic format, where available.

If a complete medical history is unable to be sent, please forward a suitable health summary and additionally include the following information (where relevant):

Date of Last Health Assessment

Date of last GP Management Plan / Reviews (721 or 732)

Immunisation History

Date of last Team Care Arrangement / Reviews (Item 723 or 732)

Copies of Specialist Letters

Date/s of Mental Health Care Plans / Reviews

Completion date of 45-49 Health Check

If sending information electronically, we prefer the following formats:

Best Practice: Complete medical history in XML Format (CD/DVD or USB)

Thank you for your care and assistance.

Yours Sincerely,

Surrey Street Family Clinic

PATIENT AUTHORITY

I hereby give authority for a copy of my medical history and the medical history of any other listed family members, to be released to Surrey Street Family Clinic in the format described above.

Patient Signature: **Date:**

Full Name (PLEASE PRINT):