Campbell Medical Practice

5/32 Blamey Place
Campbell ACT 2612
Telephone: (02) 6249 7533
Fax: (02) 6249 7003

REQUEST TO TRANSFER MEDICAL RECORDS

Your previous GP Practice details

Request to Doctor: _____ PHONE: _____

Name of practice: _____ FAX: _____

Dear Dr,

The below patient/s is/are now attending this practice on a regular basis. To assist in the further management of the health of this patient, we would appreciate you forwarding relevant medical records; health summary, latest progress notes, latest blood tests, latest X-rays/scans and all specialists reports.

If your practice uses Medical Director, we prefer files to be sent on a disc in XML format. All other medical software we would appreciate if you could send a PDF version or a hard copy paper file.

We <u>DO NOT</u> accept HTML format or USB devices for transfer of medical records.

Thank you for your assistance.

<u>Please note patients over the age of 16 MUST sign for themselves.</u>

Patient full name:

Patient date of birth:

Patient address:

Patient signature:

*<u>*For patients under the age of 16 years old:</u>*

Parent/Guardian Name:

Parent/Guardian Signature: