

Campbell Medical Practice

2/24 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 scans and all specialists reports.

**If your practice uses Helix, we require files to be sent in PDF format.
All other medical software we would appreciate if you could send a PDF version or a hard copy paper file.**

We DO NOT accept HTML or XML format for transfer of medical records.

Thank you for your assistance.

Please note patients over the age of 16 MUST sign for themselves.

Patient full name: _____

Patient date of birth: _____

Patient address: _____

Patient signature: _____

***For patients under the age of 16 years old:**

Parent/Guardian Name: _____

Parent/Guardian Signature: _____