winmante
MEDICAL CENTRE

Transfer request for medical records

Date:
Transfer from - previous Doctor/ Specialist: _____
Address of previous Doctor:

_____
_____

_____

Phone no. _____ Fax no. _____

Dear Doctor, the following patient/s are attending this clinic. Would you kindly provide:

- Relevant detailed health summary
- Current medications list
- Specialist letters (up to 5 years)
- Dates of any GPMP's, ACOC's & TCA's if applicable
- Pending recall due dates - including Pap Smear, Colonoscopy & FOBT

** please provide by fax (08) 83767395

OR

Via ARGUS

Name of patient/s:

_____ D.O.B. _____

_____ D.O.B. _____

_____ D.O.B. _____

I authorise the release of medical information and my files to be sent to Winmante Medical Centre.

Signature of Patient/s: _____

_____

_____

*** Please note some clinics may charge an administrative fee to process this request ***