

Medical History Transfer Request

To: Doctor/Clinic

Address

Re: Patient Name

Date of Birth

Address

Additional Family Members (under 18yo) requesting transfer

Date of Birth (DD/MM/YYYY)

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	/		/					
	/		/					
	/		/					
	/		/					

The patient(s) above have elected to attend Tooronga Family Medical for future medical care.

Please kindly forward a complete health summary as well as 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, copies of specialist letters, immunisation history and additionally include the following dates (where relevant):

Health Assess. (701-707)

 / /

GPMP Review (732)

 / /

45-49yo Health Check

 / /

TCA Review (732)

 / /

GPMP (Item 721)

 / /

MHCP (2700-01/2715-17)

 / /

TCA (Item 723)

 / /

MHCP Review (2712)

 / /

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 Tooronga Family Medical.

Signed

Date

 / /