"HIGH QUALITY HEALTHCARE FOR ALL"
9 Crocker Street GOOLWA SA 5214
Ph: 08 8555 2404
Fx: 08 8555 1002

REQUEST TO TRANSFER MEDICAL RECORDS

Previous Doctor/Medical Centre:	
Fax No:	
Date:	

*** (NO USB or DISKS PLEASE) ***

We wish to advise that the patient(s) listed below are now attending our Medical Centre.

To ensure continuity of care, it is requested that their medical records be transferred to this centre by registered mail. **Please do not supply these notes on Disk or by USB.**

We understand that a fee may apply and request that the patient be advised of any fees relating to the copy and transfer of their medical records.

We would also appreciate the EPC history of the patient as listed below:

Patient Surname:	
Patient Address:	

First Name: _____ **Signature**: _____ **Date of Birth**: _____

First Name: _____ **Signature**: _____ **Date of Birth**: _____

First Name: _____ **Signature**: _____ **Date of Birth**: _____

Please note that all patients over 16 years MUST sign to authorise transfer of their medical records.

EPC ITEM	COMPLETED YES/NO	DATE COMPLETED
GPMP Created (Item 721)		
TCA Created (Item 723) or review (Item 732)		
Health Assessment (Items 701,703,705,707)		
Home Medicines Review (Item 900,903)		
Mental Health Plan (Item 2715/2700,2702)		