



REQUEST FOR TRANSFER OF MEDICAL RECORDS

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|--|---|--|
| <input type="radio"/> Dr Rebecca Levy
Provider No. 408292CY | <input type="radio"/> Dr Jane Atkinson
Provider No. 236300TJ | <input type="radio"/> Dr Muditha Senanayake
Provider No. 430738GY |
| <input type="radio"/> Dr Amanda Cox
Provider No. 4202766B | <input type="radio"/> Dr Rachel Ng
Provider No. 421194LY | <input type="radio"/> Dr Kenneth Purdie
Provider No. 012139FB |
| <input type="radio"/> Dr Lisa Abdel-Malek
Provider No. 477627DH | <input type="radio"/> Dr Evelyn Clarke
Provider No. 5591772J | |

Previous Practice Name: _____

Previous Doctor: _____

Phone: _____ Fax: _____

Dear Doctor,

Re: (Patient Name): _____

DOB: _____

ADDRESS: _____

As this patient now attends this surgery, we would therefore be grateful for you to forward relevant past details or information that may be helpful in continuing management as soon as possible.

- Patient Health Summary
- Full Patient History
- Other
- Pathology/Imaging provider used: _____

*** Could you also please advise if any of the following item numbers have been performed and the appropriate dates:*

- Chronic Disease Management Plan: Item No. 721 and/or 723 _____
- Review of Chronic Disease Management Plan: Item No. 732 _____
- Health Assessment: Item No. 707, 705, 703 _____
- Mental Health Care Plan: Item No. 2715/2717 _____
- Review of Mental Health Care Plan: Item No. 2712/2713 _____
- Other: _____

*****THIS PRACTICE PREFERS TO RECEIVE CORRESPONDANCE BY MEDICAL OBJECTS*****

I/We authorise the release of my medical records to Baywest Medical Centre.

Signed: _____ Date: _____