Casuarina Health & Medical
Shop 11, Casuarina Village
482 Casuarina Way
Casuarina NSW 2487
Ph: 02 6674 0888
Fax: 02 6674 0999

CASUARINA HEALTH & MEDICAL

TRANSFER OF MEDICAL HISTORY REQUEST

Date: ……/……./…….

Attention: *(Doctor)*……..……..

(Doctor's Address) ……..…

……

Telephone No: …… **Fax No**:…….

Patient Name/s:

Name: ……..…..**Signature**……..……**DOB:**……../……../…….

Name: ……..…..**Signature**……..……**DOB:**……../……../…….

Name: ……..…..**Signature**……..……**DOB:**……../……../…….

Name: ……..…..**Signature**……..……**DOB:**……../……../…….

Current Address: ……..

Previous Address: ……..

Telephone Number/s: ……..

The above patient/s, whose signature appears below, has requested that this practice continue management and the management of the family members listed. In order to ensure continuity of care, we would appreciate a copy of the following:

For continuity of care please fax a Health Summary as soon as possible.

AND

☐ **Patient has requested the complete medical record.**

Our preferred method of receipt is either electronic via Medical Objects or Faxed or USB / Disc in XML format.
(Best Practice software)

OR

☐ **Patient has requested copies of the following:**

Health Summary
Specialist Letters
Pertinent Investigations
GP and or TCA and or Mental Health Plan

Other ……...

If you charge a fee for files to be transferred, please invoice the patient at their current provided above address'

Thank you for your assistance with the ongoing care of this patient.

I give authority for a copy of my medical history, and the medical history of the listed family members, to be released to Casuarina Health & Medical in the format described above.

Signed: …… Date: ……/……/……..