

Casuarina Health & Medical  
Shop 11, Casuarina Village  
482 Casuarina Way  
Casuarina NSW 2487  
Ph: 02 6674 0888  
Fax: 02 6674 0999  
reception@casuarinahealthandmedical.com.au



CASUARINA  
HEALTH &  
MEDICAL

### **TRANSFER OF MEDICAL HISTORY REQUEST**

Date: ...../...../.....

Attention:(Doctor).....

(Doctor's Address)

#### **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. 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

Date of last Annual Health assessment  
Date of last Mental Health Plan  
Date of last GPCCMP

**Other**.....

**Patients is now seeing: Dr Matthew Hainbach - Dr Sarah Cunningham- Dr Jacques du Toit**  
**(Please circle Dr) Dr Nathan Williams**

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

***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:** ...../...../.....