Date: _____/_____/_____

To: _____(Practice Name)

Phone: _____ **Fax:** _____

Transfer of Medical Records Request

The patient(s) named below is/are attending our practice. It would be greatly appreciated if you would kindly arrange for the full copy of Medical Records and send to:

Mountain Gate Medical Centre
43-45 Adele Avenue, Ferntree Gully, VIC 3156

(Our clinical application is Best Practice and we would appreciate information sent on disc in **XML format**. If this is not able to be supplied then we are happy to receive patient files in pdf format.) Thank you.

Patient Name: _____

Date of Birth: _____

Former Address: _____

_____

_____

Current Address: _____

_____

_____

Patient Signature: _____

Other family members to be transferred, note all patients over the age of 16 must sign.

1. Name: _____ D.O.B: _____ Signature: _____
2. Name: _____ D.O.B: _____ Signature: _____
3. Name: _____ D.O.B: _____ Signature: _____
4. Name: _____ D.O.B: _____ Signature: _____

Please advise us of any following assessments that have been completed:

GPMP	Date / /	45-49 Year Check	Date / /
TCA	Date / /	Asthmas Plan	Date / /
GP Mental Health Plan	Date / /	Medication Review	Date / /
Diabetes Cycle of Care	Date / /	CMA	Date / /