**L I N D F I E L D F A M I L Y M E D I C I N E**

[**www.lindfieldfamilymedicine.com.au**](http://www.lindfieldfamilymedicine.com.au)

**REQUEST FOR PATIENT MEDICAL RECORDS**

|  |  |  |
| --- | --- | --- |
| **SUITE 26, 12 TRYON ROAD**  **LINDFIELD NSW 2070** |  | **Phone: (02) 94167411**  **Fax: (02) 9416 8346** |

**NAME OF PRACTICE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax:…………………………………… Date: ………………………………….

***Dear Provider/Practice:*** The patient/s listed below are now attending this surgery. We would be grateful if you could forward a copy of:

a HEALTH SUMMARY and any RELEVANT MEDICAL history that will assist in the ongoing care of this patient/s AND/ OR

a COMPREHENSIVE copy of Medical Request – Patient will contact you separately to organize. Please note we accept **LARGER FILES** on **USB/CD in XML format \***

***Patient details:***

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** | **D.O. B** | | |
| Address: |  | | |
| Phone:  **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| ***Additional Family Members: (all patients over 16 years must individually sign their consent*** | | | |
| Full Name: | | D.O. B | Signature: |
| Full Name: | | D.O. B | Signature: |
| Full Name: | | D.O. B | Signature: |

**Details of any assessment/reviews that have been completed whilst under your care would be appreciated.**

|  |  |  |  |
| --- | --- | --- | --- |
| **CARE PLANS** | ***DATE:*** |  | ***DATE:*** |
| MHCP |  | GPMP (ITEM 721) |  |
| Health Assessment (701,703, 705,707) |  | TCA (ITEM 723 ) |  |

*THANK YOU* Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Requesting Doctor)*