**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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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)*