TRANSFER REQUEST FOR PATIENT MEDICAL RECORDS - CHILD

Date: ____________________

To: ____

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Patient Name: ____ D.O.B: ________________

The above-mentioned patient is now attending this practice and is under the care of:

Dr ___________________________

Can you please forward all relevant records for this patient to enable us to provide continued care. To help us access pathology and radiology reports, please provide the name of the provider(s) your clinic utilises.

Could you please forward the records via:

- Medical Objects (preferred)
- Email – reception@albanyclinic.com.au
- Fax – (07) 3264 2092

Could you please advise if the following have been performed at your surgery. If so we request that a copy of the plans be provided along with the patient records.

GP Management Plan (721) Date: ____/____/____

Team Care Arangement (723) Date: ____/____/____

Mental Health Care Plan (2710 / 2715) Date: ____/____/____

ATSI Health Assessment (715) Date: ____/____/____

I hereby authorise the transfer of my child's medical records, or a summary of my child's health information, to the doctor / practitioner listed above.

Parent / Guardian Name: ___________________________________

Parent / Guardian Signature; _________________________________ Date : ____/____/____

Y