West Brunswick Clinic *Established 1928*

Your Health Care Team

9 Melville Road Brunswick West Vic 3055
Telephone (03)9387 9088 Fax (03)9387 4238
Argus: secmail@wbc.net.au Alltalk: WBM@equery.svhm.org.au Healthlink: westbrun

Medical History Transfer Request

To: Doctor/Clinic:_____

Address: _____

Telephone:_____ Fax:_____

Re: Patient Name:_____

Date of Birth:_____

Address:_____

Additional dependants requesting transfer of history:

Name:_____ D.O.B. _____

Name:_____ D.O.B. _____

The above named patient/s have elected to attend the West Brunswick Clinic for future medical care.

Could you please send us copies of the following:

- Health Summary
- Medication List and Allergies
- Immunisations
- Investigation Results, any significant results during the last 2 years
- Correspondence, any significant correspondence/specialist letters in the last 2 years

If applicable, please include the copy of the most recent: (if copies are available, please list dates & item numbers)

- Health Assessment/CMA
- GPMP & TCA/Review
- Medication Review
- Diabetes Annual Cycle of Care

Please inform us if there are any outstanding clinical matters of significance.

We prefer NOT to receive progress notes.

If sending electronically, we prefer a XML Export from Best Practice or Medical Director on CD or via Dropbox.

If not in electronic format, for Medico Legal reasons, please do NOT send any original documents.

Regards, _____

Patient Authority

I herby give authority for a copy of my medical history of any other listed dependants, to be released to the West Brunswick Clinic in the format described above.

Patient Signature:_____ Date:_____

Print Name: _____