

258 Shannon Avenue

Geelong West 3218

Phone: 03 5223 9999

Fax: 03 5223 9955

**Patient Medical History Request**

Previous Doctor: …………………………………….

Address ………………………………………………

 ………………………………………………

Fax ………………………………………………

The below patient is now attending Health e Medical Centre for medical care.

We would be grateful to receive their history in **XML** format if your practice uses Best Practice Software, MD2 or MD3.

We would otherwise appreciate a hard copy summary, including only *recent* investigations and/or correspondence.

Patient Name: ……………………………………………

D.O.B. ……………………………

Address …………………………………………..

…………………………………………..

Dependents: (under 16 years of age – 16 years and over will need to complete their own form)

Name ……………………………………….. D.O.B …………………….

Name …………………………………….….. D.O.B ……………………..

Name ……………………………………….. D.O.B …………………….

**Patient Consent**:

I hereby authorise release and transfer of my medical history to Health e Medical Centre as requested above.

Name ………………………………………….

Signed …………………………………………..

Date ………………………….