Springwood Family Medical
Shop 10, 49-51 Cheek Avenue
Gawler East SA 5118

TEL: (08) 8523 1880
FAX: (08) 8523 1885

This form needs to be completed to request the transfer of a patient's medical records.

Date ……

To ……

……..

……..

Dear Doctor,

The Patient/s listed below is/are attending our Practice. We would be grateful if you could forward a copy of their Medical Records/Updated Medical Summaries & Specialist Letters.

Please include copies of any GP Management Plans, Team Care Arrangements, Mental Health Treatment Plans or Home Health Assessments completed within the last 12 months or any relevant information you feel could be of assistance.

Our Practice uses Best Practice Software and is able to accept records on discs that are compatible with our software (XML format).

If a fee is charged for the transfer of any patient information, please contact and advise the patient directly.

Files to be transferred

1. Patient's Name _____DOB ____/____/_____

2.Patient's Name _____DOB ____/____/_____

3.Patient's Name _____DOB ____/____/_____

Signature of the Patient/s

1._____ 2. _____ 3._____

Signatures for Patients 16yrs & over