DOCTORS OF SOUTH MELBOURNE

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Request for Medical History Transfer

Attention

Doctor ______________________________

Previous Clinic ______________________________

Phone Number ______________________________

Fax Number ______________________________

Regarding

Patient ______________________________

Date of Birth ______________________________

Mobile Phone ______________________________

Patient Information Required

- ☐ Complete Medical History
- ☐ Summary of their current Medical History

Please send the relevant medical information in XML or PDF format compatible to Best Practice.

Yours sincerely,

Doctor ______________________________

Date ______________________________

Patient Authorisation ______________________________
(signature)