DOCTORS OF SOUTH MELBOURNE

Request for Medical History Transfer

Date: _____

To:

Previous clinic: _____

Phone number: _____

Fax number: _____

Regarding:

Patient name: _____

Date of birth: _____

Mobile number: _____

Patient authority: _____
(signature)

Patient Information Required:

- Complete medical history
- Current medical history summary

Please mail the patient's relevant medical history in XML format compatible to *Best Practice* on a CD to our address below. Alternatively, you can save the information in PDF format, or if three pages or less, send via fax.

Yours sincerely,

Doctors of South Melbourne

www.doctorsofsouthmelbourne.com.au
145 Cecil St, South Melbourne, VIC 3205
P: 03 8579 6838 F: 03 8579 6840