DOCTORS OF SOUTH MELBOURNE

Request for Medical History Transfer

Date: _____

Previous clinic: _____

Phone number: _____

Fax number: _____

Patient Details:

Patient name: _____

Date of birth: _____

Mobile number: _____

Patient authority: _____
(signature)

Patient Information (please select one):

- ☐ Full Medical History (XML format only)
- ☐ Medical Summary
- ☐ Other (please specify) _____

Patient information: We'll forward this request to your **previous clinic**. They may take up to 4 weeks to process. We're not responsible for any fees associated with their transfer of medical history. If needed, please contact your previous medical clinic to follow up.

☐ I agree to the use of email and am aware this has risks to privacy and security.

Previous clinic information: Please send history in XML format compatible with Best Practice. We can accept this on a non-rewritable CD or emailed via password-protected ZIP file (if patient consent is ticked above). Any issues, please call us on the number below.

Yours sincerely,

Doctors of South Melbourne

doctorsofsouthmelbourne.com.au
145 Cecil St, South Melbourne, VIC 3205
P: 03 8579 6838 F: 03 8579 6840
reception@dosm.com.au
Healthlink EDI : docsmelb