WAVERLEY General practice
370 Blackburn Rd. Glen Waverley, 3150
Ph: (03) 9802 8155 Fax: (03) 9802 8044

MEDICAL HISTORY TRANSFER REQUEST

Previous Doctors/ Clinic Name (PRINT)_____

Previous Surgery Address: _____

_____Phone:_____Fax:_____

We would appreciate copies of all history data including, patient notes, results, documents OR Other (if applicable):_____ We request that this history be sent electronically on CD if possible.

Our practice uses Medical Director 3. If you also use Medical Director it would be appreciated if you could send a copy of their file in XML format on CD/DVD, to continue their care.

If you use any other clinical program, please provide hardcopy summary/history or PDF format on Disc.

ANY OTHER FORMAT WILL NOT BE ACCEPTED

Patients Name/s: .....D.O.B.....

.....D.O.B.....

.....D.O.B.....

.....D.O.B.....

Address: _____

_____Post code: _____ Patients

Authorisation:

I/We authorise Waverley General Practice to receive my/our full medical history.

Signed..... Date: .....

Signed..... Date: .....

Signed..... Date: .....

Signed..... Date: .....

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