REQUEST FOR MEDICAL NOTES

Date……………………………………….

Medical Practice………………………...

Fax/Email………………………………..

The following person/family has now become a patient of Thrive Family Practice. Please forward a copy of their medical records and any recent results and care plans.

Name: ______________________ **DOB:**__________________

Name: ______________________ **DOB:**__________________

Name: ______________________ **DOB:**__________________

Please advise the dates and/or reviews of assessments that may have been completed whilst under your care.

- GPMP
- TCA
- Aboriginal health assessment
- Over 75 health assessment
- Cervical screening test
- Mental health care plan

Patient Authority: ____________________________

Date: ____________________________

Electronic correspondence preferred via HealthLink.

Thrive Family Practice
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