Arana Hills Medical Centre

Arana Hills Plaza Patrick's Rd. Arana Hills Qld 4054

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FAMILY MEDICAL PRACTITIONERS

MUSCULOSKELETAL, SKIN CANCER & HEALTHY WOMAN CARE

Request for Transfer of Records

Date: _____

Previous Clinic Details: _____

Phone:_____**Fax/ Email:** _____

Patient name: _____ **Date of Birth:** _____

Current address: _____

PERMISSION TO OBTAIN MEDICAL RECORDS

I hereby give permission for my/our medical records to be forwarded as requested.

Signature: _____ **Date:** _____

The above patient(s) has indicated that they wish to attend this practice.
It would be appreciated if you could provide a health summary and copies of any relevant test results.

COULD YOU ALSO PLEASE ADVISE THE LAST DATE THESE SERVICES WERE PERFORMED:

Item Number	Date Billed
721	
723	
732	
2700, 2701, 2715, 2717	
2712	
701, 703, 705, 707, 715, 699	

Please include file summaries for family members as indicated below.

Patient name: _____ Date of Birth: _____

Patient name: _____ Date of Birth: _____

Our preferred method of transfer is Medical Objects. We cannot receive records on disk.
Records to be forwarded to:

Dr Neil Hearnden 0263331F
Dr Lauren-Phoebe Neilsen 4609254X
Dr Bree Stone 428069BF
Dr Michael Yelland 036125BA
Dr Michelle Parry 223537KY
Dr Miranda Coleman 5779724