



11/2109-2111 Fifteenth Street
Irymple, VIC 3498
Ph 03 5024 5746
Fax 03 5024 6894

TRANSFER OF RECORDS

(Where possible XML format, No email of files please)

Date: -----

Previous Doctor/Practice:

Address: -----

Phone: -----

Fax: -----

Could you please forward all medical records/specialist letters of the patient/patients to Irymple Medical Centre as he/she is now attending this Surgery for medical care

Please also notify us if Patient has previously had any of the following and dates, they were done;

Mental Health Plan/or Review	Yes/No	Date.....
GPMP (72, 723, 731)	Yes/No	Date.....
Health Assessment	Yes/No	Date.....

Irymple Medical Centre uses MD for its clinical records, where possible an electronic transfer on CD in MB3 format is requested.

Re: Name:.....DOB:.....

Address:.....
.....

Patient Signature:

Doctor/Admin: