CRAFTER HEALTH

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HAWTHORN SA 5062

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MEDICAL RECORDS REQUEST

Date: ____/____/____

Transfer from: Dr: _____

Surgery Name: _____

Address: _____

Phone: _____

Patient name: _____

Address: _____

Date of birth: _____

Other family members (only complete if they will be attending this clinic & under 18yrs old)

Patient name: _____

Date of birth: _____

Patient name: _____

Date of birth: _____

The patient(s) named above are now seeing Dr _____.
Would you please provide them with a complete copy of their medical records (if you have Best Practice or Medical Director, please provide notes on CD in XML format), to assist us with their ongoing care.

Could you please provide dates of previous assessments or reviews if applicable.

GPMP:	Date: ____/____/____
TCA:	Date: ____/____/____
GP Mental Health Plan	Date: ____/____/____
Home Health Assessment	Date: ____/____/____
Other: _____	Date: ____/____/____

Thank you.
I _____ authorise the release of medical information from my files to be sent to the doctor named above.

Signed: _____ **Date:** ____/____/____