Alice Street
General Practice

Dr Nyrie Dodd
Dr Aneale Uppal
Dr Jennifer Gunn
Dr Mitch Squire
Dr Leanne Ellis
Dr Sarah Sen
Dr Neetu Aggarwal
Dr Lawrence Vaux
Dr Rachel Jones
Dr Sara Berry

6 Alice Street, NEWTOWN NSW 2042
Ph (02) 9550 6201 Fax (02) 9550 1094
www.alicestreetgp.com.au

Request to Transfer Medical Records

Date:_____/_____/_____

Request to: _____

Address:_____

Fax Number:_____Phone Number:_____

We wish to advise that the patient(s) listed below are now attending our medical practice.

Name	DOB	Address
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____

To ensure continuity of care, it is requested that their medical records be transferred to this practice. Our practice uses Best Practice software and requests that patient records are sent on CD in XML format (if applicable). We understand that a fee may apply and request that the patient be advised directly of any fees relating to the copy and transfer of their medical records.

Would you please advise us the dates of any assessments and/or reviews of assessments that may have been completed whilst the patient/s were under your care.

Assessment/Review Items	Completed Yes/No	Date Completed
GPMP Created (Item 721)		
TCA Created (Item 723)		
Health Assessment (Items 701, 703, 705, 707)		
Home Medicines Review (Item 900)		
Mental Health Plan (Item 2700/2701/2715/2717)		
Mental Health Plan Review (Item 2712)		

I/We,_____state that I/we have read the above information and have consented to having previous records sent to the Alice Street General Practice.

Signed:_____Date:_____/_____/_____

Signed:_____Date:_____/_____/_____

**Please note that all patients over 16 years of age MUST sign to authorise transfer of their medical records*