THE NEIGHBOURHOOD CLINIC

Medical Record Transfer Request

Patient Name ______________________________

D.O.B ______________________________

Address ____

Dear Doctor ____________________________

Clinic name ____________________________

Clinic Address ____

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The above-mentioned patient will be attending The Neighbourhood Clinic.

Please forward all medical history, investigations, test results, referrals and relevant information. It would also be appreciated if you could send dates (if relevant) of the most recent

GPMP (Date) …………………………….

GPMP Review (Date) …………………

MHCP (Date) …………………………….

MHCP Review (Date) …………………

TCA Plan (Date) ……………………………….

TCA Plan Review (Date) ……………………

Health Assessment (Date) …………………..

to:

The Neighbourhood Clinic
329-331 St Georges Road
Fitzroy North 3068.

Phone: (03) 9043 6568
Fax: (03) 9977 5852

Yours sincerely,
Dr Vin Menezes
Dr Oi Mun Chan
Dr Emily MacDonald

Patient signature……………………………………………………………………… **Date**………………………