Kaurna Country **194a Chandlers Hill Road, Happy Valley SA 5159**
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Healthlink EDI: CHANDLER

Transfer of Files Request Form

Fax: _____ Date: _____

Doctor Name: _____

Surgery Name: _____

Address: _____

The following patient/s are now attending this practice and have requested that copies of relevant information from his/her medical history be forwarded to us. Please supply a complete and up-to-date patient **summary.** If you have Best Practice please provide notes in **XML** format or via a USB.

Patient Name: _____dob_____

Patient Name: _____dob_____

Patient Name: _____dob_____

Address on your records: _____

	PATIENT NAME	DETAILS	DATE BILLED
GPMP CREATED Item 965			
GPMP Last reviewed Item 967			
HA Item 701 - 707			
HMR Item 900			
MHCP Item 2702 or 2710			
MHCP Review Item 2712			
Last CST – including name of laboratory			

Patient Signature: _____ Date _____

Patient Name: _____
(Signed release required for all patients over 16 years of age)

Name: _____

Office use only:
Faxed to Clinic ☐ **Scanned to Patient File** ☐ **Entered on Spreadsheet** ☐