

# Alice Street General Practice

6 Alice Street, NEWTOWN NSW 2042  
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**Dr Nyrie Dodd**      **Dr Sarah Sen**  
**Dr Neetu Aggarwal**   **Dr Leanne Ellis**  
**Dr Jennifer Gunn**      **Dr Lawrence Vaux**  
**Dr Mitch Squire**      **Dr Rachel Jones**  
**Dr Sara Berry**  
**Dr Mihal Guttman-Jones**

## 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