MILTON

MEDICAL CENTRE

AND SKIN CANCER CLINIC 02 4455 5755

TO:…………………………………… DATE: ……………………………

……………………………………

……………………………………

This patient has recently moved to the area and is now attending Milton medical Centre. Could you please forward any medical history which may help us with the ongoing care of this patient.

My name is………………………………………………DOB……..............

Address …………………………………………………

……..……………………………..................................

Could you please include other members of my family as listed:

………………………………………………………………………..………DOB……......

…………………………………………………………………………………..DOB……….....

Signature of the person requesting:……………………………………………………………

Name of Doctor to whom the record is being sent:…………………………………………………...

Thank you, Doctor's signature:……………………………………….

<u>Please advise the following;</u>

ITEM	COMPLETED	DATE LAST BILLED
GPMP (721/723)	YES/NO	_____/_____/_____
GPMP Review (732)	YES/NO	_____/_____/_____
CMA (703, 705, 707)	YES/NO	_____/_____/_____
Health Assessment (701 – 715)	YES/NO	_____/_____/_____
HMR/DMMR (900)	YES/NO	_____/_____/_____
Mental Health Plan (2700/2701 Or 2715/2717)	YES/NO	_____/_____/_____
Mental Health Review (2712)	YES/NO	_____/_____/_____

AS THIS PRACTICE IS A "PAPERLESS" SURGERY WE WOULD PREFER TO RECEIVE INFORMATION ON A DISC WHICH IS COMPATIBLE WITH BEST PRACTICE. IF YOU USE A DIFFERENT SYSTEM A PAPER COPY SUMMARY OF THE MOST RECENT PATIENT HISTORY WOULD BE APPRECIATED.