



**REQUEST FOR PATIENT MEDICAL RECORDS**

Dr. Elveya D’Couto	Dr. Victoria Foster	Dr. Naychi Oo
Dr. Sam Fazio	Dr. Vibha Chaudhary	Dr. Htet Oo
Dr. Colin Chng	Dr. Ikechukwu Onwuegbuna	

Date: \_\_\_/\_\_\_/\_\_\_\_\_

Urgent:  YES  NO

TO:	Dr’s Surgery - _____
ATTENTION :	Dr - _____
FAX NO/EMAIL:	_____
FROM :	Brecken Health - Reception
SUBJECT:	Transfer of relevant patient/s history

The following patient has requested a **Patient Health Summary** of their records/discharge summaries/specialist letters to be transferred to this practice. **WE USE BEST PRACTICE SOFTWARE.**

NAME: .....

DOB: .....

ADDRESS: .....

Any particular information we would like is listed here:

.....  
.....

Could you also advise if any care plans / health assessments have been done and their dates.

Thank you in anticipation of your willingness to provide continued quality healthcare.

For Brecken Health - on behalf of Dr: .....

**My Consent for the above is given** *(Patient to sign below)*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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