Request to Transfer Medical Records

Date: _____

Name of Previous Surgery: _____

Fax Number: _____

We wish to advise that the patient(s) listed below are now attending our practice. To ensure continuity of care, could you please forward all relevant past and present medical history that will assist in our management of this patient(s).

Patient Name: _____ Date of Birth: _____

Address: _____

Signature: _____

Additional Family Members:

First Name: _____ Signature: _____ Date of Birth: _____

First Name: _____ Signature: _____ Date of Birth: _____

First Name: _____ Signature: _____ Date of Birth: _____

First Name: _____ Signature: _____ Date of Birth: _____

Yours Sincerely

Power Medical Centre

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