THE HAWKINS MEDICAL CLINIC

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M STERCK MBBS
V SELVARATNAM MBBS

Date: / / Fax:……

Dear Dr ……
Clinic……
Address……State……
Phone Number……..

The following patient now attend(s) our surgery, having formerly been your patient(s).

Would you kindly provide us with a summary of your medical records to assist us with ongoing care. If sending electronic records please make sure they are in HTML format.

Yours sincerely,

Doctor's signature ……

Patient Details

Name……
Date of Birth ……
Phone Number……..
Current Address……
……
……
Previous Address……
……
……

Family Members (under 16 years)

Name……
Date of Birth ……

Name……
Date of Birth ……

Name……
Date of Birth ……

Patient's Signature……Date:……

Witness Signature: …… Name:……

Please advise if this patient/s has had any type of Care Plan, Review or Health Assessment completed at your clinic. Thank you.

ITEM	DATE	ITEM	DATE
2715/2717	….. ……..	Health Assessment	……
721	……..	900 HMR	……..
723	……	Pap Smear	……..
732	……		

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