South Perth Hospital

Request for Transfer of Patient Information

SURNAME	UMRN
GIVEN NAMES	
D.O.B	SEX
ADDRESS	

Use Patient I.D. label when available

PATIENT DETAILS

Title: (please tick) Mr Mrs Miss Ms	Date of Birth:
Surname:	First Name:
Previous Surname (if applicable):	
Address:	

DETAILS OF REQUESTOR

Name of Medical Practice:	
Name of Requesting Doctor/Health Care Provider:	
Address:	
Email :	
Telephone:	Fax:

INFORMATION REQUIRED (Information requested can be sent via post, fax or encrypted email.)

Discharge Summary

Endoscopy or Colonoscopy Reports

Other: (Please specify)

PATIENT CONSENT

I, the above named patient, consent to the release of my past and present health information to the Doctor/Health Care Provider making this request. I acknowledge that there may be a cost involved in the provision of this information and I will be responsible for payment.

_____ Date: _____

(Patient Signature)

CLINICAN / PRACTICE CERTIFICATION

I confirm that the information requested is required for the patients current treatment.
The patient 's next appointment is _____/_____/_____.

Name:_____ Signature: _____ Date: _____

(Requesting Clinician or Health care Provider)

FEE

A fee of $30 may be charged for provision of this information. This fee covers the administrative costs involved in supplying the requested information including reproduction costs. Where the cost of reproduction exceeds $30 an additional fee may be charged. The fee must be paid prior to the provision of the information.

Please send this completed form to the Health Information Manger at **MedicalRecords@sph.org.au** or fax to **(08) 6436 4378**.

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