



CUNNINGHAME ARM MEDICAL CENTRE

ABN 43006 576 343

8 Whithers Street (P.O. Box 198) Lakes Entrance 3909

Tel: (03) 5155 2300 Fax: (03) 5155 2499

www.camc.com.au

email: camc@camc.com.au

Previous Clinic Details:

Clinic Name: _____

Doctor: _____

Address: _____

Phone: _____ Fax: _____

Patient Details:

Name: _____

D.O.B: _____

Address: _____

Dear Doctor,

This patient has recently attended our practice. I would appreciate it if you could send as summary of his/her medical history. We use **MEDICAL DIRECTOR** and are happy to receive the requested history on CD.

Please also provide dates for the following (if applicable):

GPMP: __/__/__ TCA: __/__/__ Health Assessment: __/__/__

Diabetes cycle of care: __/__/__ Asthma cycle of care: __/__/__

Please do not send original records

Medical Director history can be sent on a CD.

If using Best Practice, Zedmed or another program, history can be emailed using PDF format.

Dr

Provider Number:

I hereby authorise Dr: _____ to send details of my medical history to the Cunninghame Arm Medical Centre.

Signed: _____

Date: __/__/__