Mount Compass Medical Centre

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Dr Vikki Mclaughlin
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Request for Previous Medical History
NO DISCS PLEASE / MD Exchange preferred

Date: _____

Previous Clinic Details:

Doctor: _____ Medical Centre _____

Address: _____

Phone: _____ _____ Fax: _____ _____

Patient Details:

Name: _____ D.O.B: _____ Signed: _____

Name: _____ D.O.B: _____ Signed: _____

Name: _____ D.O.B: _____ Signed: _____

Address: _____

Patient Authority:
I request that a copy of my **Health Summary, specialist letters & any other relevant information** be forwarded to the Mount Compass Surgery. **All patients 16 years of age and over MUST sign.**

The above patient/s is/are now attending this practice and we would appreciate a copy of their health summary & relevant medical history to assist us with their ongoing care. **Please include any EPC History including new and reviews with date of completion.**

		Date		Date
GPMP	721		MHCP	
TCA	723		MHCP rev	
45-49	701			
75+	707			

Kind regards,

Reception