flagstaff hill
MEDICAL CENTRE

1 Ridgway Drive
Flagstaff Hill SA 5159
T: 08 8270 1194
F: 08 8370 7668
E: reception@fhmc.net.au

Date: _____

Dear Dr: _____

Of (Surgery): _____

Address: _____

Phone No.: _____ **Fax No.:** _____

The following patient/family has transferred their care to our surgery. We would be grateful if you could forward their clinical information and notes to our surgery for continuity of their care.

Please find below their names and signatures of the involved patients who give permission for their records to be sent to Flagstaff Hill Medical Centre.

Patient Name: _____ **DOB:** _____ **Signed:** _____

Patient Name: _____ **DOB:** _____ **Signed:** _____

Patient Name: _____ **DOB:** _____ **Signed:** _____

Patient Name: _____ **DOB:** _____ **Signed:** _____

Patient Name: _____ **DOB:** _____ **Signed:** _____

Yours Sincerely

Flagstaff Hill Medical Centre