FERRERS medical clinic

2-4 Wehl Street North
(PO Box 438)
Mount Gambier SA 5290
ABN 11 049 673 399

T: (08) 87254261
F: (08) 87238233
E: ferrersclinic@ferrers.com.au
Website: www.ferrers.com.au

WRITTEN AUTHORITY

TO OBTAIN INFORMATION FROM ANOTHER PRACTICE – HOSPITAL – RESULTS OR RADIOLOGY

TO: (DR or CLINIC) _____

ADDRESS: _____ FAX: _____

I, the undersigned, request that you provide Ferrers Medical Clinic, as per their request, with a SUMMARY of my medical records, results, discharge, letter and or any such other information that may be relevant to my/ my family's medical history.

- **If the patient has had any type of Care Plans, Care Plan Reviews or Health Assessments prepared by your practice please complete the following:**

GP Management Plan	YES / NO	Date complete:
Team Care Arrangement	YES / NO	
75+ Health Assessment	YES / NO	
GP Mental Health Care Plan	YES / NO	
GP Mental Health Care Plan Review	YES / NO	
Medication Management Review – Home	YES / NO	
Workcover Claims	YES / NO	(if yes please provide details):

DATE: _____

PATIENT'S FULL NAME _____

D.O.B. _____ **ADDRESS** _____

SIGNATURE _____

2nd PATIENT FULL NAME _____

D.O.B. _____ **SIGNATURE (if over 16)** _____

3rd PATIENT FULL NAME _____

D.O.B. _____ **SIGNATURE (if over 16)** _____

Separate signatures are required for all persons over 16 years of age

PLEASE NOTE: There may be an administration fee charged by your previous clinic

FORM 18 - AUTHORITY FOR INFORMATION FROM ANOTHER PRACTICE