

# McKinley Medical Centre

## Request for Medical History Transfer

**Date:** \_\_\_\_\_

**To:**

Previous clinic: \_\_\_\_\_

Phone: \_\_\_\_\_

Practice Email: \_\_\_\_\_

**Regarding:**

Patient name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Mobile number: \_\_\_\_\_

Patient authority: \_\_\_\_\_  
(signature)

Or parent/guardian: \_\_\_\_\_  
(signature)

**Patient Information Required:**

- Complete medical history
- Current medical history summary

*Please mail the patient's relevant medical history in XML format compatible to Best Practice on a CD or USB to our address below. Alternatively, you can email us the information to our email address below.*

Yours sincerely,  
McKinley Medical Centre

**[www.mckinleymc.com.au](http://www.mckinleymc.com.au)**  
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