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Dr. Jo Adendorff      Provider No. 278580EK      Dr Vrisha Kerr      Provider No. 5570191T  
Dr Elizabeth Hicks      Provider No. 299062CY      Dr James Williams      Provider No. 470119DF  
Dr Clinton Leahy      Provider No. 455060YY

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

Dear Dr: \_\_\_\_\_

Address: \_\_\_\_\_

Ph: \_\_\_\_\_ Fax: \_\_\_\_\_

The following patient(s) now attend our Medical centre and request an up to date patient health summary including all other relevant information from your records for the below mentioned patient(s).

RE: \_\_\_\_\_ DOB: \_\_\_\_\_  
RE: \_\_\_\_\_ DOB: \_\_\_\_\_  
RE: \_\_\_\_\_ DOB: \_\_\_\_\_

Please advise of dates of any of the following assessments that may have been performed:

GMP	Date: _____
TCA	Date: _____
GPM/Health Plan	Date: _____
Diabetes Cycle of Care	Date: _____
Asthma Sycle of Care	Date: _____
Health Assessment	Date: _____
45 year Health Check	Date: _____
Cervical Screening (PAP)	Date: _____
Immunisation	_____

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Patient Signature

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Date