

THAMES MEDICAL CENTRE

PO Box 710

Thames 3500

Email: office@thamesmed.co.nz

EDI: Thames

GP2GP (Preferred)

Dr M Parle	20459	<input type="checkbox"/>
Dr D Stapleton	20478	<input type="checkbox"/>
Dr A Poortier	14712	<input type="checkbox"/>
Dr S Gunn	30057	<input type="checkbox"/>
Dr K Hennessy	12509	<input type="checkbox"/>
Dr A Ireland	29559	<input type="checkbox"/>
Dr V Jouan	77190	<input type="checkbox"/>

REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED

Each person 16 years or over to complete and sign own form

In order to receive the best care possible, I agree to the Thames Medical Centre obtaining my medical records from my previous doctor. I also understand that I will be removed from their practice register.

To:
[Name of previous Doctor or Medical Centre]

Address:
.....

Please transfer the medical records for the following people to Thames Medical Centre.

Family Name	Given Names	Date of Birth

Current Address:
.....

Patient/Caregiver Signature: _____ Date: _____

Fax Back Acknowledgement: Medical Records Received

Medical Centre: _____ Date: _____

Signed: _____

Office Use Only: Entered into Medtech: <input type="checkbox"/>	Date:	Initial:	Scanned: <input type="checkbox"/>	Date:	Initial:
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