

REQUEST FOR COPY OF REPORT

FACSIMILE

COMPANY:	TO: HISTOLOGY DEPARTMENT
ATTN:	DATE:
FAX NO:	NO. OF PAGES: (including cover sheet)
SUBJECT: REQUEST FOR COPY OF REPORT	

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PLEASE COMPLETE ALL INFORMATION

We request a copy of the relevant medical records to ensure ongoing medical care for this patient.

Urgent

Full Name _____

DOB _____

Case Information(eg: date range, case number etc) _____

Patient's Signature(if available) _____ Date _____

NB: If patient is unavailable, the requesting doctor may sign on their behalf.

Requesting Doctor [Print Name] _____

Requesting Provider Number _____

Doctor's Signature _____ Date _____

Please send report via:

Fax – Clinic fax number: _____

Download

Please fax the completed request to (07) 4796 8882

ABN 68 151 578 675

South City One

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