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	

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
Unit 6, 3245 Logan Road, Underwood, Brisbane, QLD, 4119
T: 1300 007 284 F: 07 4796 8882
Email: admin@infinitypath.com.au
Website: www.infinitypath.com.au