The Royal Children's Hospital Melbourne

Request for Adolescent Transition

(for transfer to adult healthcare)

UR NUMBER

SURNAME

GIVEN NAME(S)

DATE OF BIRTH

AFFIX PATIENT LABEL HERE ↑

Date of request: ____________________________ Date required: ___________________________________

Name of requestor (print) ___________________ Signature ______________________________________

Contact number/pager ______________________

Part A - Medical record documents	**Specify date range/dates**	**Health Information Services staff** initial on completion or N/A
○ All correspondence	(last 3 years)	
○ Additional correspondence (must be tabbed or printed off)		
○ discharge summaries		
○ operation reports		
○ Adolescent Transition Program forms (MR143/C & MR144/C)		
○ Pathology results	(last 3 years)	
○ Additional Pathology (must be tabbed or printed off)		
○ copy of visit list from IBA/CLARA		
○ other documents (must be tabbed or printed off)		
○ Additional USB for adult health service		

HIS to forward this form and USB to Medical Imaging on completion of Part A.

Part B - Medical Imaging		**Specify date range/dates**	**Medical Imaging staff** initial on completion or N/A
X-ray	○ images		
	○ reports		
pgs Ultrasound	○ images		
	○ reports		
CT SCAN	○ images		
	○ reports		
○ other imaging (Please specify)			
○ Additional disk for adult health service			

Medical Imaging to forward this form, USB and disc to the Transition Support Service.
Contact details ext: 54980, pager: 5312 on completion of Part B.