Health Information Services

Change of Patient Details form

Please provide the UR number, current name and new/correct details

Please use BLOCK LETTERS

UR number _____

Surname _____

Affix PMI label

(if available)

Change of name

Name currently on IBA: Surname _____

Given name _____

New/Correct name: Surname _____

Given name _____

Sighted Medicare card or Change of name documentation ☐*(tick box)*

Change of address (Please indicate if Mothers', Fathers', or Other (specify) also need changing)

New/Correct address: _____

_____

_____

Mother ☐ Father ☐ Other ☐ Please specify_____

Telephone Number (Please indicate if Mothers', Fathers', or Other (specify) also need changing)

Correct phone number: _____

_____

Mother ☐ Father ☐ Other ☐ Please specify_____

Date of Birth

Correct DOB: _____/_____/_____

Medicare Number Change

_____ Exp Date: _____

Form completed by

Name: _____ Date: _____

Department: _____ Ext: _____

Please send form to

Health Information Services RCH
Patient Information Request Line
Fax: 6589 Ext: 6107
Or affix to front of medical record

Additional copies

www.rch.org.au/rchhis/requests