

**Healthcare Provider Request for
Participant Screening Histories form**

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| --- | --- | --- | --- |
| Provider Full Name: |  | Medicare Provider Number: |  |
| **Practice Name and address linked to Medicare Provider Number:**  |  |
| **Name of Requesting Staff Member:** |  | **HCP/clinic fax number:** |  |

* I wish to request the cervical screening histories of my patients listed in the table below.
* I am requesting this information from the NCSR for the purposes of cervical screening management.

| IHI  | Medicare/DVA | First Name | Surname | DOB | Address | Suburb | Postcode |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1234567891234567 | 98765412456 | Sample | Test | 02.02.1988 | 123 Test St | Sample South | 1234 |
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**NCSR fax number:** 1800 627 702