

MEDICARE CARD NUMBER

PATIENT SURNAME	GIVEN NAME(S)	SEX	DATE OF BIRTH	YOUR REFERENCE
PATIENT ADDRESS	POSTCODE	TELEPHONE	TEL (ALTERNATE)	

TESTS REQUESTED

CLINICAL NOTES

SD Do Not Send Report to My Health Record

URGENT PHONE FAX BY TIME:
 PHONE/FAX No.:
 PRIVATE SCHEDULE MEDICARE
 VETAFFAIRS/WORK COMP No.:

DOCTOR'S SIGNATURE AND REQUEST DATE

X

Fasting

Non Fasting

Pregnant

Hormone Therapy

LMP

EDC

Cervical Cytology

SITE: Cervix

Vaginal Vault

Endometrium

Other

Post Natal

Post Menopausal

Radio Therapy

IUCD

Abnormal Bleeding

APPEARANCE OF CERVIX: Benign

Suspicious

COPY REPORTS TO: REFERRING DOCTOR (NAME, PROVIDER NUMBER, ADDRESS)

COLLECTION

LOCATION	INITIALS
C V A I S D	
DATE	TIME

Practitioner's Use Only (Reason for Patient unable to sign)

Hospital status of patient at specimen collection or date of service

Private patient in a private hospital or approved day hospital facility	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Private patient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>
Public patient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient of a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT'S SIGNATURE AND DATE

Is the patient the assignor: Yes No

By this declaration I assign my right to benefits to the Approved Pathology Practitioner who will render the requested pathology service(s) and any pathology-determinable service.

X

I certify that I collected the accompanying specimen from the above patient whose identity was confirmed by enquiry and/or examination of their ID wristband, and that I labelled the specimen immediately following collection before leaving the patient.

SIGNED: NAME (Print):

TUBES				URINE				SWABS					SLIDES		CONTAINERS			OTHER					
GEL	PLAIN	EDTA	EDTA 9 mL	FLOX	CITRATE	HEPARIN	TRACE	BACTO	CYTO	24HR	PCR	ORANGE	WHITE	GREEN	RED	PINK	BACTO	CYTO	FAECES	SEMEN	HISTO	DESCRIBE	

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PATIENT COPY