CLINPATH PATHOLOGY

# Request Form

Patient Details *(please print)*

| Surname | Given Names | Sex ☐M ☐F |
|---|---|---|
| Address | Phone Number<br><br>Consent to SMS result: Y / N<br>Sign: | Date of Birth |

| Clinical Details | Medicare number |
|---|---|
| ☐Urgent ☐Phone ☐Fax By time _____<br><br>Phone/Fax number: _____<br><br>☐ Private ☐Concession ☒ Bulk Bill<br><br>Veteran's affairs gold card no. _____ | Medicare assignment<br>I offer to assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner<br><br>Signature X _____ |

Tests Requested

**COVID PCR only (D299)**

| Requesting Details | Copy To |
|---|---|
| Doctor: _____<br><br>Clinic: _____<br><br>Provider #: _____ | St. Andrew's Hospital Pre Admission **STA/PRE**<br><br>St. Andrew's Infection Control **C153** |

Office Use Only

**ATTENTION: DOCTORS/NURSES/PHLEBOTOMISTS**
DECLARATION: I certify that I collected the accompanying sample from the above patient whose identity was confirmed by enquiry and/or examination of their name band and that I labelled the sample immediately following collection.

Name: _____
Signature: _____
Date: _____ Time: _____

| Location Code | Collector Code | Referral Date | Collection Date | Time | Service Date |
|---|---|---|---|---|---|
| | | | | | |

| Gel | Clot | EDTA | Gluc | Cit | Hep | Urine | Faeces | Body Fluid | Sputum | CSF | Histo | Pap | Swab | ECG-Tracing | Other | Initials |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | |