Request Form

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RCPA
Accredited for compliance with NPAAC Standards and ISO 15189 and ISO/IEC 17025

NATA
Accreditation Number 3158

MEDICARE CARD NUMBER

western diagnostic pathology

PATIENT LAST NAME | GIVEN NAME/S | SEX | DATE OF BIRTH | YOUR REFERENCE

PATIENT ADDRESS | TEL (HOME) | TEL (BUS) | MOBILE

POSTCODE

TESTS REQUESTED

LABORATORY COPY

- Fasting ☐
- Non fasting ☐
- Pregnant ☐
- Hormone therapy ☐
- LNMP ☐
- EDC ☐

Cervical Cytology

Site: Cervix ☐ | Vaginal vault ☐ | Endometrium ☐ | Other ☐

- Post natal ☐
- Post menopausal ☐
- Radiotherapy ☐
- IUCD ☐
- Abnormal bleeding ☐
- Appearance of cervix: Benign ☐ | Suspicious ☐

CLINICAL NOTES

CERVICAL SCREENING TEST: ☐ Practitioner Collect ☐ Self-Collect
LBC AND HPV TESTS NOT MEETING CRITERIA ARE ***NOT*** COVERED BY MEDICARE

PENSION CARD NO.

HEALTHCARE CARD NO.

REPAT. GOLD CARD NO.

TRANSFUSION

ENSURE TUBE & DECLARATION HAVE BEEN SIGNED
Date required: Time:
Reason for Transfusion/operation:

In the past three months has the patient been
Pregnant? ☐ YES ☐ NO
Transfused? ☐ Yes ☐ NO

☐ SD (Self Determined)

URGENT ☐ PHONE FAX ☐ BY TIME

PHONE/ FAX NO:

PRIVATE ☐ CONCESSION ☐ BULK BILL ☐

VET AFFAIRS ☐

DOCTOR'S SIGNATURE AND REQUEST DATE

✗ .....

COPY REPORTS TO:

REQUESTING DOCTOR (PROVIDER NUMBER, SURNAME INITIALS, ADDRESS)

HOSPITAL/WARD:

☐ Tick if patient requires copy of this request form

PERSON DRAWING BLOOD TO COMPLETE:
I certify that the blood specimen accompanying this request was drawn from the patient stated as established by direct enquiry of the patient and/or inspection of the ID wrist-band, and that specimen was labelled immediately.
I have also signed the sample tube.
NAME:

SIGN: **DATE:**

PATIENT STATUS AT TIME OF THE SERVICE OR WHEN THE SPECIMEN COLLECTED:	YES	NO
1. Private patient in a private hospital or approved day hospital facility	☐	☐
2. Private patient in a recognised hospital	☐	☐
3. Public patient in a recognised hospital	☐	☐
4. Outpatient of a recognised hospital	☐	☐

Laboratory Use ONLY	SPECIMEN COLLECTED	SPECIMENS RECEIVED	ACC
Date: Time:	Collector	Rec. by:	

MEDICARE ASSIGNMENT (Section 20A of the Health Insurance Act 1973) *I offer to assign my right to benefits to the approved pathology practitioner ("APP") who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner. In the event that I am issued with an account for those services, I also authorise that APP to submit my unpaid account to Medicare so that Medicare can asssess my claim and issue me a cheque payable to the APP for the Medicare benefit.*

Practitioner Use Only:
(Reason patient cannot sign) .....

PATIENT'S SIGNATURE AND DATE

✗ ...../...../.....

DETACH HERE

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PATIENT LAST NAME | GIVEN NAMES (INCLUDING MIDDLE INITIAL) | SEX | DATE OF BIRTH | YOUR REFERENCE

PATIENT ADDRESS | TEL (HOME) | TEL (BUS)

TESTS REQUESTED

PATIENT COPY

REQUESTING DOCTOR *(PROVIDER NUMBER, SURNAME, INITIALS, ADDRESS)*

Privacy Note: The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of the government health programs, and may be used to update enrolment records. Its collection is authorised by provisions of the *Health Insurance Act 1973*. The information may be disclosed to the Department of Health and Ageing or to a person in the medical practice associated with this claim, or as authorised/required by law.

CLEAR SAVE EMAIL

WDP-RF050_eReq_V2_Dec23