PATHOLOGY REQUEST FORM

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Title	Surname	First	DOB	Sex
[f: 94]	[f: 3]	[f: 1]	[f: 6]	[f: 95]

Address: [f: 14]

Suburb: [f: 15]	**Post Code:** [f: 16]	**State:** [f: 17]
Home Ph: [f: 93]	**Work Ph:** [f: 97]	**Mobile:** [f: 96]

Medicare Number: [f: 98]

Medicare Assignment (Section 20A of the Health Insurance Act 1973) I assign my right to benefits to the approved Pathology Practitioner Who will render the requested pathology service(s)

Patients Signature:	**Date:**

The information provided by you on this form will be used to access the benefit payable for services rendered. Its collection is authorized by law and its contents may be disclosed to the Department of Health and Ageing, to the person claiming the benefit for the service or to the person's nominee. The person making the claim may be advised of your eligibility under the scheme

Collected By	Date	Time

Account Type	Private	**BULK BILLED**

Clinical Notes/ Therapy	**Tests Requested**	**LAB USE**
Path for monitoring purposes. Pt currently taking Bio Identical Hormone Replacement Therapy. No Need to Fast Do not take morning dose prior to this test	**ESTRADIOL** **PROGESTERONE** **TOTAL TESTOSTERONE** **SHBG** **CALCULATED FREE TESTOSTERONE**	
INSTRUCTIONS	**Blood test preferably to be taken between 8am – 10am**	

Doctors Signature: 

Date: 22/06/2017