DOCTORS: Please complete ALL relevant areas in the red section

Patient Details

HOSPITAL

GENDER M F | UR PREFIX | UR NO | DATE OF BIRTH

PATIENT SURNAME (Please print or place sticker on this area) | PATIENT FIRST NAME

PATIENT ADDRESS | CONTACT NO

Medicare Details

Patient status at the time of the service or when specimen collected (please tick) Yes

- Private patient in a private hospital or approved day hospital facility
- Private patient in a recognised hospital
- Public patient in a recognised hospital
- Outpatient at a recognised hospital
- Bulk Bill Rural & Remote COAG

PATHOLOGY USE ONLY

MEDICARE NUMBER

HEALTH FUND NAME | EXP

VETERANS AFFAIRS | IRN

Indigenous status: Aboriginal | Non-Indigenous | TSI | Both | Not stated

MEDICARE ASSIGNMENT FORM (Section 20A of the Health Insurance Act 1973) I offer to assign my rights 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

Patient Signature X | Date / /

PRACTITIONERS USE ONLY (Reason patient cannot sign)

Collector

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

SURNAME OF COLLECTING PERSON (Please print) | INITIALS

Signature: | *Date Collected* / / | *Time Collected* | AM PM

Collection Details

COLLECTION CODE

- Path QLD Collect Inpatient
- Path Qld Collect Outpatient
- Ward Collect
- Self Collect
- Self Collect Assist
- Others
- Patient Fasting
- PEI

CONTAINERS COLLECTED (No of Tubes)

EDTA	LHEP	FL OX
SST	EDTA BBANK	URINE
RST	BL Culture	SWAB
CITRATE	ABG	HISTO

OTHER

REC'D TIME

Request Details

LAB NO

WARD/CLINICAL UNIT

LAB USE ONLY

TEST REQUESTED

CLINICAL NOTES/MEDICATIONS | GESTATIONAL AGE K=

Not for My Health Record ☐

Requesting Officer

CONSULTANT/SENIOR MEDICAL OFFICER SURNAME (Please print) | INITIALS

SURNAME OF REQUESTING OFFICER (Please print) | AUSLAB CODE

FIRST NAME | PROVIDER NUMBER

Requesting Doctor's Signature X | Date Requested / / | Self Determine ☐

URGENT | TEL | PAGE | FAX | CONTACT NO

Copy

COPY REPORT TO: SURNAME (Please print) | INITIALS

COPY REPORT TO ADDRESS

V131018PU