CLINPATH PATHOLOGY

21 James Congdon Drive
Mile End SA 5031
ABN 17 008 204 251

Sonic Healthcare Limited A.P.A. ABN 24 004 196 909
Level 22, Grosvenor Place, 225 George Street Sydney NSW 2000

MEDICARE NUMBER

8366 2000
All hours

A/4337

SURNAME | MR, MRS, MISS, MS, DR. | GIVEN NAME(S) | SEX | DATE OF BIRTH | YOUR REFERENCE

ADDRESS | TEL (HOME) | TEL (BUS)

TESTS REQUESTED

LABORATORY COPY

CONTAINERS COLLECTED

COLLECTOR CODE

CLINICAL NOTES

- Fasting
- Non Fasting
- Pregnant
- Horm Therapy
- LMP
- EDC
- CERVICAL CYTOLOGY
- SITE Cervix
- Vaginal Vault
- Endometrium
- Other
- Post Natal
- Post Menopausal
- Radiotherapy
- IUCD
- Abnormal Bleeding
- APPEARANCE OF CERVIX Benign
- Suspicious

❑ SD

❑ Rule 3 Exemption ❑ Repeat Request Form

URGENT ☐ PHONE ☐ FAX ☐ BY TIME

PHONE / FAX No.:

PRIVATE ☐ CONCESSION ☐ BULK BILL ☐

VETERAN'S AFFAIRS GOLD CARD No.:

Your doctor has recommended that you use Clinpath. You are free to choose your own pathology provider. However, if your doctor has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor.

Please see reverse for Blood Transfusion and Gynaecological Cytology requests.

DOCTOR'S SIGNATURE AND REQUEST DATE

✗ ...../...../.....

COPY REPORTS TO

HOSPITAL / WARD

REQUESTING DOCTOR (SURNAME, INITIALS, ADDRESS & PROVIDER No.)

Doct					
Copy 1					
Copy 2					
Copy 3					
Hosp/Ward					

MEDICARE ASSIGNMENT
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.

✗ ..../...../.....
Patient's Signature Date

PRACTITIONERS USE ONLY

Reason Patient Cannot Sign

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: _____ Date: _____

Sign: _____ Time: _____

PATIENT STATUS at the time of the service or when the specimen was collected

	yes	no
Private patient in a private hospital or approved day hospital facility	☐	☐
Private patient in a recognised hospital	☐	☐
Public patient in a recognised hospital	☐	☐
Outpatient of a recognised hospital	☐	☐

Patient Collection Centres over page

NAME: D.O.B.: PULL

NAME: D.O.B.: PULL

NAME: D.O.B.: PULL

BEND TO REMOVE LABELS

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PATIENT COPY

REQUESTING DOCTOR (SURNAME, INITIALS, ADDRESS & PROVIDER No.)

National Cancer Screening Register (NCSR)
The National Cancer Screening Register (NCSR) is an 'opt out' register. Pathology laboratories can no longer act on 'not for register' instructions on the pathology request form. Patients who wish to alter their consent status must contact the register directly on 1800 627 701.

MEDICARE ASSIGNMENT
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.

✗ ..../...../.....
Patient's Signature Date

PRACTITIONERS USE ONLY

Reason Patient Cannot Sign

11/19