ADELAIDE SKIN

PATHOLOGY

P: 08 8120 4799
F: 08 8120 4788
191 South Road,
Mile End, SA, 5031
ACN 603 472 831

Medicare Card Number:

PATHOLOGY REQUEST

ASP_R01_A4RS_07

PH 08 8120 4799

Patient Last Name: | Given Names: | Sex: | Date of Birth: | Your Patient Code:

Patient Address: | Postcode: | Tel (Home): | Tel (Work):

Tests Requested:

LABORATORY COPY

Lab Use:

Conditions:

- Fasting ☐
- Non-Fasting ☐
- Pregnant ☐
- Horm Therapy ☐
- LNMP ☐
- EDC ☐
- Site Certix ☐
  - Vaginal Vault ☐
  - Endometrium ☐
  - Other ☐
- Post Natal ☐
- Post Menopausal ☐
- Radio Therapy ☐
- IUCD ☐
- Abnormal Bleeding ☐
- Benign Appearance ☐
- Suspicious Appearance ☐

Clinical Notes: | Self Determine: ☐

Collector's Signature:
I certify that the pathology specimen accompanying the request was collected from the patient stated above as established by direct enquiry and/or inspection of wrist band.

Signature

Date | Time

Urgent ☐ | Phone Result ☐ | Fax Result ☐ | By:

Phone / Fax No:

Private ☐ | Concession ☐ | Bulk Bill ☐

Vet. Affairs / HCC No:

Doctor's Signature: | Request Date:

Copy of Reports to:

Requesting Doctor's Surname and Initials, Address, and Provider Number:

Status of patient at specimen collection or date of service:	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 in a recognised hospital	☐	☐

MEDICARE ASSIGNMENT: (Section 20A of the *Health Insurance Act 1973*) By this declaration I 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.

PRACTITIONER'S USE ONLY (reason patient cannot sign) | Patient Signature | Date

ADELAIDE SKIN

PATHOLOGY

191 South Road, Mile End, SA, 5031
www.adelaideskinpathology.com.au

NAME: | DOB: | LIFT

NAME: | DOB: | LIFT

NAME: | DOB: | LIFT

PATHOLOGY REQUEST FORM - PATIENT COPY PLEASE DETATCH

Medicare Card Number:

Patient Last Name: | Given Names: | Sex: | Date of Birth: | Your Patient Code:

Patient Address: | Postcode: | Tel (Home): | Tel (Work):

Tests Requested:

PATIENT COPY

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 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.

Patient Advisory Statement: Your treating practitioner has recommended that you use Metropath. You are free to choose your own pathology provider. However, if your treating practitioner has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service(s). You should discuss this with your treating practitioner.

Requesting Doctor (Provider Number, Surname and Initials, Address):

Status of patient at specimen collection or date of service:	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 in a recognised hospital	☐	☐

MEDICARE ASSIGNMENT: (Section 20A of the *Health Insurance Act 1973*) By this declaration I 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.

PRACTITIONER'S USE ONLY (reason patient cannot sign) | Patient Signature | Date