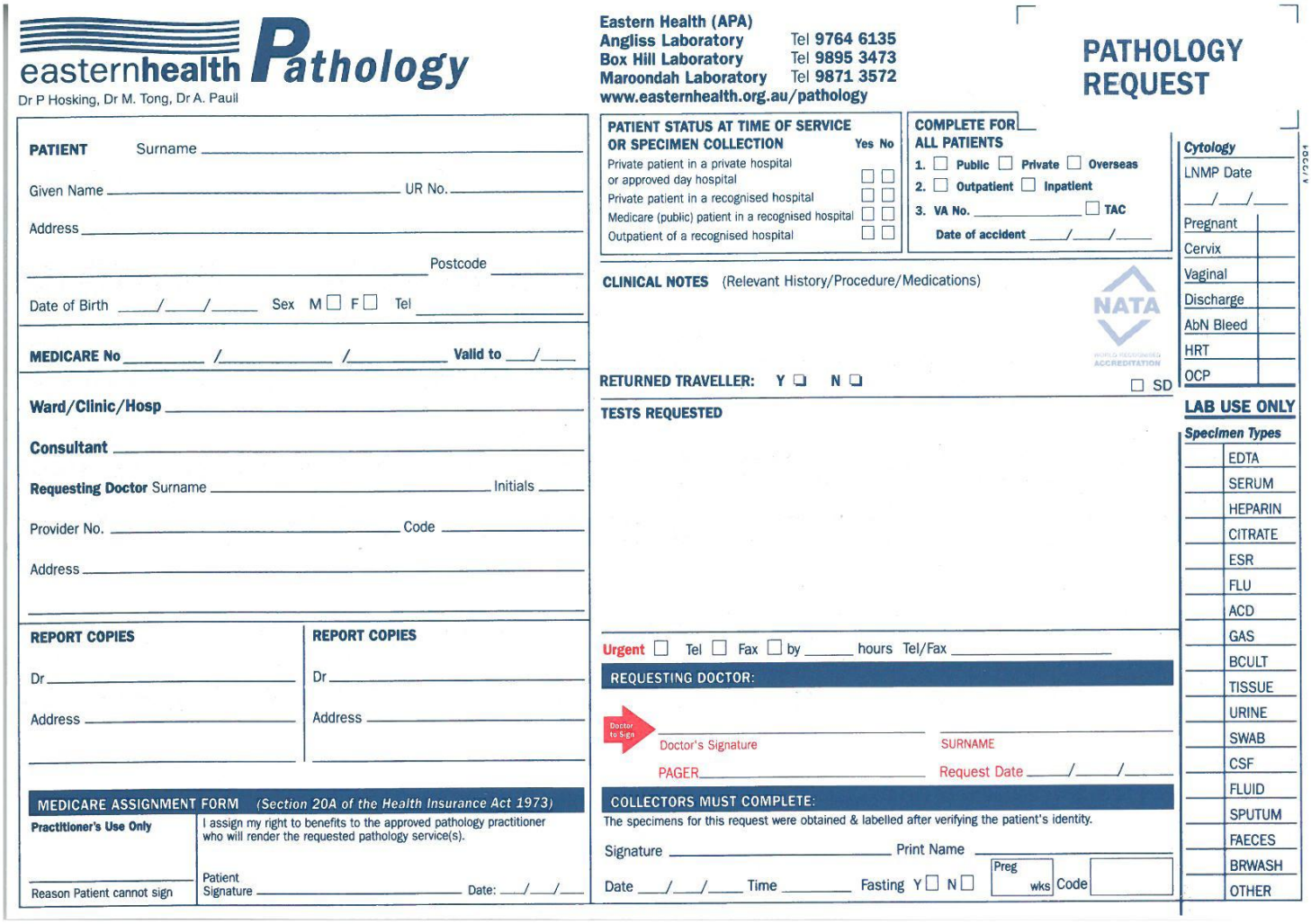

easternhealth Pathology

Dr P Hosking, Dr M. Tong, Dr A. Paull

Eastern Health (APA)
Angliss Laboratory Tel 9764 6135
Box Hill Laboratory Tel 9895 3473
Maroondah Laboratory Tel 9871 3572
www.easternhealth.org.au/pathology

PATHOLOGY REQUEST

PATIENT Surname

Given Name UR No.

Address

Postcode

Date of Birth ___/___/___ Sex M ☐ F ☐ Tel

MEDICARE No ___ / ___ / ___ Valid to ___/___

Ward/Clinic/Hosp

Consultant

Requesting Doctor Surname Initials

Provider No. Code

Address

PATIENT STATUS AT TIME OF SERVICE OR SPECIMEN COLLECTION

	Yes	No
Private patient in a private hospital or approved day hospital	☐	☐
Private patient in a recognised hospital	☐	☐
Medicare (public) patient in a recognised hospital	☐	☐
Outpatient of a recognised hospital	☐	☐

COMPLETE FOR ALL PATIENTS

1. ☐ Public ☐ Private ☐ Overseas
2. ☐ Outpatient ☐ Inpatient
3. VA No. ☐ TAC

Date of accident ___/___/___

CLINICAL NOTES (Relevant History/Procedure/Medications)

NATA

RETURNED TRAVELLER: Y ☐ N ☐ ☐ SD

TESTS REQUESTED

Cytology
LNMP Date ___/___/___

Pregnant	
Cervix	
Vaginal	
Discharge	
AbN Bleed	
HRT	
OCP	

LAB USE ONLY

Specimen Types

	EDTA
	SERUM
	HEPARIN
	CITRATE
	ESR
	FLU
	ACD
	GAS
	BCULT
	TISSUE
	URINE
	SWAB
	CSF
	FLUID
	SPUTUM
	FAECES
	BRWASH
	OTHER

REPORT COPIES

Dr

Address

REPORT COPIES

Dr

Address

MEDICARE ASSIGNMENT FORM (Section 20A of the Health Insurance Act 1973)

Practitioner's Use Only

Reason Patient cannot sign

I assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s).

Patient Signature Date: ___/___/___

Urgent ☐ Tel ☐ Fax ☐ by ___ hours Tel/Fax

REQUESTING DOCTOR:

Doctor to Sign

Doctor's Signature SURNAME

PAGER Request Date ___/___/___

COLLECTORS MUST COMPLETE:

The specimens for this request were obtained & labelled after verifying the patient's identity.

Signature Print Name

Date ___/___/___ Time Fasting Y ☐ N ☐ Preg wks Code

Warfarin Dosing Questionnaire **Rule 3 exemption** ORIGINAL REQUEST DATE:_____

Contact Telephone Number:_____

Was the last INR performed at another site or Laboratory? Y/N Where/ When_____

What is the current dose of Warfarin ?_____

Any changes in medication at all since last test (eg: aspirin, laxatives, antibiotics, vitamins/ dietary supp.) ?

If yes please list:_____

Any recent or current illness or hospitalisation ?_____

Any recent bleeding, bruising or blood in the urine ?_____

Any missed Warfarin tablets recently ?_____

Any major changes in diet ?_____

Other information (eg: impending travel plans, alternative contact details if not at normal contact)