

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 _____	
REPORT COPIES	
Dr _____	Dr _____
Address _____	Address _____
MEDICARE ASSIGNMENT FORM (Section 20A of the Health Insurance Act 1973)	
Practitioner's Use Only	I assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s).
Reason Patient cannot sign _____	Patient Signature _____ Date: ____/____/____

PATIENT STATUS AT TIME OF SERVICE OR SPECIMEN COLLECTION	
Private patient in a private hospital or approved day hospital	Yes ☐ No ☐
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)



RETURNED TRAVELLER: Y ☐ N ☐ ☐ SD

TESTS REQUESTED

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 _____

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

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)