Hospital-use Request Form

Results Hotline 136199

Accredited for compliance with NPAAC Standards and ISO 15189 and ISO/IEC 17025

Accreditation Number 3158

UR NUMBER

At least three identifiers must be on both request forms and specimen: Surname, Given Name and DOB or URN

SURNAME:

NAME: **Affix Patient Label Here**

ADDRESS:

DOB:

SEX: ☐ MALE ☐ FEMALE Medicare Card Number: ____________________

CLINICAL HISTORY:

☐ SD (Self Determine) Do not send reports to My Health Record ☐

URGENT please phone/Page on: ____________________

☐ Pregnant ☐ Post CVA ☐ MVA ☐ Diabetic ☐ OD ☐ Fasting

TESTS REQUESTED

MICROBIOLOGY SAMPLES

Sample/site: Test:

COPY TO:

HOSPITAL:

WARD:

PATIENT BED No.: ....

TRANSFUSION

ENSURE TUBE & DECLARATION HAVE BEEN SIGNED

Date required: **Time:**

Reason for Transfusion/operation:

In the last three months has the patient been:

Pregnant? ☐ **YES** ☐ **NO**

Transfused? ☐ **YES** ☐ **NO**

THERAPEUTIC DRUG MONITORING

DRUG	Daily Dose	Last Dose mg	Date	Time

Laboratory use only ACC

Date

Time

Specimens	EDTA	SST	CIT	FLOX	K2	Others	SIGN
Collected							
Received							

Person collecting blood to complete:

I certify that the blood specimen accompanying this request was drawn from the patient stated as established by direct enquiry of the patient and/or inspection of the ID wrist-band, and that the specimen was labelled immediately. I have also signed the sample tube.

Name:

Sign:

Date:

Dr Signature Request Date: ____________________

Requesting Dr Name: ____________________

Hospital practice (if not on patient label attached): ____________________

Provider No: ____________________

Privacy Note: The information provided will be used to access any Medicare benefit payable for the services rendered and to facilitate the proper administration of the 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 status at time of the service or when the specimen was collected:

(a) Private patient in a private hospital or approved day hospital facility Yes ☐ No ☐

(b) Private patient in a recognised hospital Yes ☐ No ☐

(c) Public patient in a recognised hospital Yes ☐ No ☐

(d) Outpatient in a recognised hospital Yes ☐ No ☐

WDP-RF0010-AVI

Specialist Diagnostic Services Pty Ltd ABN 84 007 190 043 t/a Western Women's Pathology APA No. 000042 **Suite 2, 178 Cambridge Street Wembley WA 6014**

www.wdp.com.au **www.saferworkplace.com.au** **PH: (08) 9317 0999** **FX: (08) 9317 1536**

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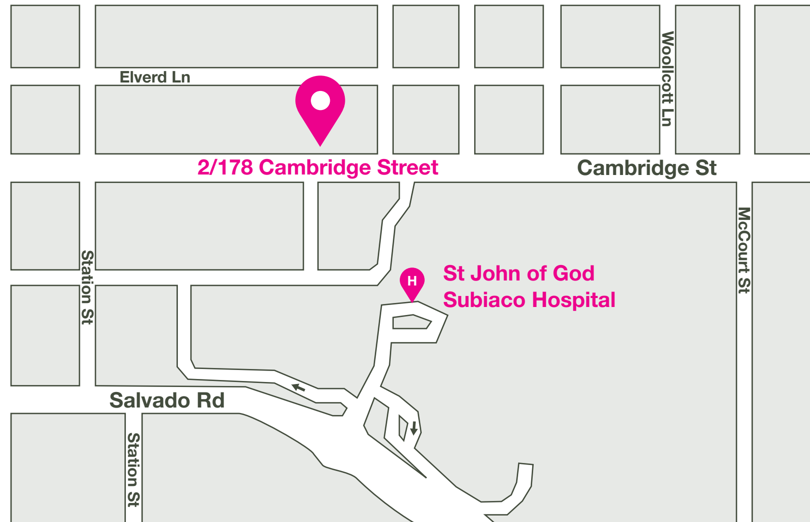
Western Women's PATHOLOGY

A new era in women's pathology



A women's-focused pathology centre for all pathology tests.
Specialising in Generation®/Generation plus® testing and Glucose Tolerance Testing.

- ♀ Specialised Gynaecological Pathologists onsite
- ♀ Bulk billing
- ♀ Luxurious patient amenities for superior comfort

Your treating practitioner has recommended that you use Western Women's Pathology. 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. You should discuss this with your treating practitioner.

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