GENERAL PATHOLOGY REQUEST FORM + LABELS

General Enquiries | Doctor Enquiries

MEDICARE CARD NUMBER & IRN:

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www.clinicallabs.com.au General 2	NOT THE REAL PROPERTY OF THE P						
TITLE PATIENT SURNAME GI	VEN NAME (INCLUDING MIDDLE INITIAL)	SEX	DATE OF BIRTH		YOUR REFE	RENCE	
	PO	STCODE	MOBILE PH		ALTPH		
ESTS REQUESTED						Fasting Non Fasting	
						Pregnant	
COVID PCR							
						LNMP EDC	
						CERVICAL CYTOLOGY	
UNICAL NOTES						SITE Cervix Vaginal Vault	
						Endometrium	
_						Post Natal	
RULE 3 EXEMPTION SELF DETERMINED						Post Menopausal	
REPEAT FORMS	PERSON COLLECTING SPECIMEN(S) TO COMPLETE					Radio Therapy	
PHONE FAX BY TO	examination of their name-band, and that I labelled the	rom the v and/or sample	DOCTOR'S SIGNATUR	RE AND REQUEST DATE Abnormal Bleeding			
PHONE/FAX No.: PRIVATE SCHEDULE FEE BULK BILL	immediately following collection. SIGNED: ACOLLECTOR NAME:				action of the second se	OF CERVIX Benign Suspicious	
/ET AFFAIRS No.:	DATE: / / TIME: :	X	DOCTOR	DAT	E: 1 1		
TFlinders Lane Bedford Park SA **BEDICARE ASSIGNMENT (Section 20A of the Health Insurance Act 1973) I offer to assist the approved pathology practitioner who will render the requested pathology service(s) are eleminable service(s) established as necessary by the practitioner. In the alternate I au abs to submit my uppaid occount to Department of Human Services so that Departmen sess my claim and issue a cheque to me payable to Australian Clinical Labs for the Medi tractitioner's Use Only (Reason patient cannot sign): **TUBES*** **URINE** **SEL** EDTA** FLOX SOD CIT** ESR** HEP** PLAIN MSU** CYTO** 24 HR** PC **OLD & TEAR** **ABELLING REQUIREMENTS** **Complete PATIENT NAME and DATE OF BIRTH prior to attaching to specimen** **PLACE LABEL VERTICALLY** **IF MORE THAN 3 specimens please write patient details on additional receivables.** **PLACE LABEL VERTICALLY** **IF MORE THAN 3 specimens please write patient details on additional receivables.** **PLACE LABEL VERTICALLY** **IF MORE THAN 3 specimens please write patient details on additional receivables.** **PLACE LABEL VERTICALLY** **IF MORE THAN 3 specimens please write patient details on additional receivables.** **PLACE LABEL VERTICALLY** **IF MORE THAN 3 specimens please write patient details on additional receivables.** **PLACE LABEL VERTICALLY** **IF MORE THAN 3 specimens please write patient details on a stabilization and stabilization are second.** **PLACE LABEL VERTICALLY** **IF MORE THAN 3 specimens please write patient details on a stabilization and stabilization are second.** **IF MORE THAN 3 specimens please write patient details on a stabilization and stabilization and stabilization are second.** **IF MORE THAN 3 specimens please write patient details on a stabilization and stabili	See over for Billing SLIDES CONTAINERS	g Policy and P SW UNG CSF DATE: NAME:	ATE: / / rivacy Note	Patient sta specimen 1. Private or appro 2. Private 3. A public 4. Outpatie T	PITAL PATIENTS tus at the time of the was collected: patient in a private ho oved day hospital faci patient in a recognise patient in a recognise ant of a recognised ho ATE: AME:	spital yes no ity	
additional specimens PCPA The decrease as a seed of second seed to the MATASPA AND SECOND					MEDICARE CAI		
OLD & TEAR AUSTRALIAN Clinicalabs www.clinicallabs.com.au General Enc 1300 453	Amendment Shering Commission (Commission Commission Com		EQUEST FORM			24.000.74.100.000	
	IVEN NAME (INCLUDING MIDDLE INITIAL)	SEX	DATE OF BIRTH		YOUR REFE	RENCE	
PATIENT ADDRESS	PC	OSTCODE	MOBILE PH		ALT PH		

TESTS REQUESTED

REQUESTING DOCTOR (PROVIDER NUMBER, SURNAME & INITIALS, ADDRESS)