

General Enquiries
1300 453 688

Doctor Enquiries
1300 134 111

| | | | | | |
|-------|-------------------|---------------------------------------|----------|---------------|----------------|
| TITLE | PATIENT LAST NAME | GIVEN NAME (INCLUDING MIDDLE INITIAL) | SEX | DATE OF BIRTH | YOUR REFERENCE |
| | | | | | |
| | | | POSTCODE | MOBILE PH | ALT PH |

TESTS REQUESTED

Fasting
 Non Fasting
 Pregnant
 Horm Therapy

LNMP
 EDC
 CERVICAL CYTOLOGY

SITE Cervix
 Vaginal Vault
 Endometrium
 Other
 Post Natal
 Post Menopausal
 Radio Therapy
 IUCD
 Abnormal Bleeding
 APPEARANCE OF CERVIX Benign
 Suspicious

CLINICAL NOTES

RULE 3 EXEMPTION
 SELF DETERMINED
 REPEAT FORMS

PERSON COLLECTING SPECIMEN(S) TO COMPLETE

I certify that I collected the accompanying sample from the above patient, whose identity was confirmed by inquiry and/or examination of their name-band, and that I labelled the sample immediately following collection.

SIGNED: X COLLECTOR FULL NAME: _____
 DATE: / / TIME: : : _____

DOCTOR'S SIGNATURE AND REQUEST DATE

X DOCTOR DATE: / /

URGENT PHONE FAX BY TIME: _____

PHONE/FAX No.: _____

PRIVATE SCHEDULE FEE BULK BILL

VET AFFAIRS No.: _____

COPY REPORTS TO:

HOSPITAL/WARD:

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

MEDICARE ASSIGNMENT (Section 20A of the Health Insurance Act 1973) I offer to 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. In the alternate I authorise Australian Clinical Labs to submit my unpaid account to Department of Human Services so that Department of Human Services can assess my claim and issue a cheque to me payable to Australian Clinical Labs for the Medicare benefit.

PENSIONER/HCC HOLDER - PATIENT'S SIGNATURE AND DATE

X PATIENT DATE: / /
 See over for Billing Policy and Privacy Note

FOR HOSPITAL PATIENTS
 Patient status at the time of the service or when the specimen was collected:

| | | |
|--|--------------------------|--------------------------|
| 1. Private patient in a private hospital or approved day hospital facility | yes | no |
| 2. Private patient in a recognised hospital | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. A public patient in a recognised hospital | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Outpatient of a recognised hospital | <input type="checkbox"/> | <input type="checkbox"/> |

| TUBES | | | | URINE | | | | SLIDES | | CONTAINERS | | | | SWABS: | OTHER: | | | | | | |
|-------|------|------|---------|-------|-----|-------|-----|--------|-------|------------|------|-------|------|--------|--------|--------|------|------|-----|--|--|
| GEL | EDTA | FLOX | SOD CIT | ESR | HEP | PLAIN | MSU | CYTO | 24 HR | PCR | CHEM | MICRO | CYTO | LBC | HIST | FAECES | SPUT | FUNG | CSF | | |



General Enquiries
1300 453 688

Doctor Enquiries
1300 134 111

YOUR PATHOLOGY REQUEST

MEDICARE CARD NUMBER

PATIENT COPY

| | | | | | |
|-------|-------------------|---------------------------------------|----------|---------------|----------------|
| TITLE | PATIENT LAST NAME | GIVEN NAME (INCLUDING MIDDLE INITIAL) | SEX | DATE OF BIRTH | YOUR REFERENCE |
| | | | | | |
| | | | POSTCODE | MOBILE PH | ALT PH |

TESTS REQUESTED

PATIENT COPY

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

IMPORTANT NOTE: Your doctor has recommended that you use Australian Clinical Labs. You are free to choose your own pathology provider. However, if your doctor 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 doctor.

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 or to a person in the medical practice associated with this claim, or as authorised/required by law.