QML Pathology

Specialist Diagnostic Services Pty Ltd (ABN 84 007 190 043) t/a QML Pathology APA No.000042
11 Riverview Place, Metroplex on Gateway, Murarrie, Qld, 4172. Ph (07) 3121 4945

DO NOT BULK BILL
Request to be pre-paid at time of collection by Credit Card ONLY.

PATIENT SELF REQUEST FORM

PATIENT FAMILY NAME	GIVEN NAMES	SEX	DATE OF BIRTH	FILE No.

PATIENT ADDRESS	POSTCODE	TEL (HOME & MOBILE)	TEL(BUS)

TESTS REQUESTED

Is patient: *Fasting* ☐ *Non Fasting* ☐

Patient self request - PRIVATE & CONFIDENTIAL

Please tick test/s you require:

☐ **Hair Drug Screen**

☐ **Carbohydrate Deficient Transferrin (CDT)**

QML Pathology Use:

Request must be PRE-PAID AT TIME OF COLLECTION by Credit Card ONLY

Pre-Paid Receipt Number:

Photo Identification Sighted:
☐ Drivers License ☐ Passport ☐ Other: _____ ID Number: _____

The appropriate Chain of Custody form MUST be completed for the above tests.
Collector must tick box below to confirm form has been completed.

☐ **Hair Drug Screen Chain of Custody completed**

☐ **Carbohydrate Deficient Transferrin (CDT) Chain of Custody completed**

Consult patient and complete below - TICK ONE OPTION ONLY:

☐ Laboratory report delivered to Patient address as indicated on this request form. (Note: Patient Results **CANNOT** be emailed)

☐ Laboratory report to be picked up from this Collection Centre by patient*:

ACC code: _____ ACC phone number: _____

**Advise patient to CALL COLLECTION CENTRE prior to picking up laboratory report (photo identification will be required).*

COLLECTOR DECLARATION (*Tick where applicable*)

I certify: The results documented on this form are from the sample provided to me by the Donor who has given signed certification below.

☐ The specimen has been collected in compliance with the requirements of the Standard (AS4308).

☐ I hold a Certificate in Specimen Collection that includes Drugs of Abuse testing.

COLLECTOR NAME: ..... ***COLLECTOR SIGNATURE:*** ..... ***DATE:*** ...../...../.....

PATIENT'S SIGNATURE AND DATE

I confirm that the information provided on this form by myself to QML Pathology is true and correct. I understand that I will receive a copy of this form and that a laboratory report will be delivered in the method indicated above.
I have read and understood the disclaimer at the bottom of the page.

✗..... ...../...../.....
PATIENT'S SIGNATURE ***DATE***

REQUESTING DOCTOR, WORKPLACE HEALTH AND SAFETY OFFICER

PATIENT SELF REQUEST **VPS2E**
QML Pathology
Doctor Maintenance Department
11 Riverview Place
MURARRIE QLD 4172

PUB/MR/01449_TOW_V2_Dec17

Disclaimer: QML Pathology advises that pathology tests are usually requested by a patient's doctor as they are medically qualified to interpret and/or analyse the results. QML Pathology offers a limited range of self requested pathology tests because some panels of testing are complex and there may be the possibility of misinterpretation of pathology results in the absence of medical symptoms discussed as part of a medical consultation. Patients requesting self determined testing will need to consult their local medical professional if they require interpretive advice.

LABEL USE	Collect Date	Coll. Time	Test Codes	Branch	Ref. No.	Lab. No.	Description & Containers	Collector
	Received Date	Rec. Time		B/C PP	Clinic			