# 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*

## Patient self request - PRIVATE & CONFIDENTIAL

*DO NOT SEND REPORTS TO MY HEALTH RECORD* ☐

**Please tick test/s you require:**

- ☐ **Blood Group**
- ☐ **MMR (Measles, Mumps, Rubella)**
- ☐ **Hep A Immune Status**
- ☐ **Hep B Immune Status**
- ☐ **Varicella Immune Status**
- ☐ **Mantoux Testing**
- ☐ **Quantiferon Gold**

## 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: _____

**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**

**I certify:** The blood specimen(s) accompanying this request was drawn from the patient named above. I established the identity of this patient by direct inquiry and/or inspection of wrist band and immediately upon the blood being drawn I labelled the specimen(s).

***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** **SPS3Y**
QML Pathology
Doctor Maintenance Department
11 Riverview Place
MURARRIE QLD 4172

PUB/MR/01404_V7_May21 SOU

**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.

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