

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

PATIENT'S SIGNATURE

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 L	BIRTH	FILE No.	
PATIENT ADDRESS PC						TEL (HOME & MOBILE)		TEL(BUS)	
TESTS REQUESTED									
Patient self request	- PRIVATE	<u>& CONFIDEN</u>	<u>TIAL</u>				DO NOT SE	END REPORTS TO	MY HEALTH RECORD [
On-Site Instant Saliva D	rug Screen (D)S6)							
QML Pathology Use:									
Request must be PRE-PAID AT	TIME OF COLLEC	CTION by Credit Ca	rd ONLY	Pre-Paid	Receip	ot Numb	oer:		
Photo Identification Sighte ☐ Drivers License ☐ Pa		□ Other:			1[) Numb	er:		
Testing Device Name:	Batch I	Number:	Expiry D	ate: /	/				
Drug Class	Amphetamines	Methamphetamine	Cocaine	Opiates		THC	Benzodiazepines	Oxycodone	Other/Specify
Aust Std (AS4760) Target Value	50 ng/mL	50 ng/mL	50 ng/mL	50 ng/m	L 1:	5 ng/mL	10 ng/mL	40 ng/mL	
Cut-off Level (ng/mL) (if different to Aust Std)									
Initial Test Result									
Key: N = Negative U = Unconfirm	med Positive (requi	res confirmatory testin	g) $X = Not Te$	ested					
☐ Patient requests Laborato Must be paid before specimen					760				
Consult patient and complete Laboratory report delivered			this request	form. (Not	e: Patie	ent Resul	ts CANNOT be en	nailed)	
☐ Laboratory report to be pi								,	
ACC code:			ACC phone	number: _					
*Advise patient to CALL COLLECTION		o picking up laborato	ry report (pho	oto identifica	ation w	ill be requ	ired).		
I certify: The results documente		e from the sample p	rovided to m	ne by the Do	onor w	ho has gi	ven signed certific	ation below	
☐ The specimen has been collect	cted in compliand	e with the requirem	ents of the S	tandard (A		_	veri signed certine	ation below.	
□ I hold a Certificate in Specime		J.							
COLLECTOR NAME:		CO	LLECTOR SIGN	ATURE:	••••••••••			DATE:	//
	ENT'S SIGNATURE						DOCTOR, WORKPLACE I		
I confirm that the information p and correct. I understand that I v results and that a laboratory rep I have read and understood the	will receive a copy oort will be delivere	of this form with the i ed in the method indic	initial screenii		QML I Docto	Patholog	nance Departme Place	MPS1V	N

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.

DATE

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	Collect Date	Coll. Time	Test Codes	Branch	Ref. No.	Lab. No.	Description & Containers	Collector	
L U A S B E	Received Date	Rec. Time		B/C PP	Clinic				