_									
Pecialist Diagnostic Services Pty Ltd (ABN 84 007 190 043) t/a QML Pathology APA No.000042 1 Riverview Place, Metroplex on Gateway, Murarrie, Qld, 4172. Ph (07) 3121 4945		DO NOT I Request to be pr collection by Cr	PATIENT SELF REQUEST FORM						
ATIENT FAMILY NAME	GIVEN NAMES	SE	C DATE OF BIRTH		FILE No.				
ATIENT ADDRESS		POSTCODE	TEL (HOME & MOBILE)		TEL(BUS)				
TESTS REQUESTED Patient self request Please tick test/s you requ	PRIVATE & CONFIDENTIAL				ls patient:	Fasting □ Non Fasting □			
□ Hair Drug Screen									
□ Carbohydrate Deficient	Transferrin (CDT)								
QML Pathology Use:									
Request must be PRE-PAID AT TI	ME OF COLLECTION by Credit Card ONL	Pre-Paid Rece	ipt Number:						
Photo Identification Sighted:			ID Number:						
The appropriate Chain of Custody form <u>MUST</u> 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									
□ Laboratory report to be picke	elow - TICK ONE OPTION ONLY: o Patient address as indicated on this req ed up from this Collection Centre by patie ACC pł	ent*:							
	I CENTRE prior to picking up laboratory report	c (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.

DATE

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:

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.

X.....

D

PATIENT'S SIGNATURE

REQUESTING DOCTOR, WORKPLACE HEALTH AND SAFETY OFFICER PATIENT SELF REQUEST SPS3Y QML Pathology Doctor Maintenance Department 11 Riverview Place **MURARRIE QLD 4172**

..... DATE:/...../...../......

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.

	1		- 5	5		-			
	Collect Date	Coll. Time	Test Codes		Branch	Ref. No.	Lab. No.	Description & Containers	Collector
LU									
AS	Received Date	Rec. Time			B/C	Clinic			
					PP				