qml pathology

RCPA The Royal College of Pathologists of Australasia | NATA WORLD RECOGNISED ACCREDITATION

Accredited for compliance with NPAAC Standards and ISO 15189
Accreditation Number: 2184

MEDICARE CARD NUMBER

PATHOLOGY REQUEST

PATIENT LAST NAME | GIVEN NAMES | SEX | DATE OF BIRTH | FILE No.

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

TESTS REQUESTED

LABORATORY COPY

- Fasting ☐
- Non Fasting ☐
- Pregnant ☐
- Horm Therapy ☐
- LMP ___/___/___
- EDC ___/___/___

Cervical Screening

- Cervix ☐
- Vagina ☐
- Self Collect ☐
- Post Natal ☐
- IUCD ☐
- PCB/PMB ☐
- Abnormal Bleeding ☐
- Cx Suspicious ☐
- Previous AIS ☐
- Radiotherapy ☐
- Immune deficient ☐

CLINICAL NOTES

☐ SELF DETERMINED
☐ STANDARD PRECAUTIONS ☐ PRIVATE & CONFIDENTIAL ☐ CUMULATIVE ☐

URGENT ☐ PHONE ☐ FAX ☐ BY TIME:
PHONE/FAX No:
QML Fee ☐ S.F. ☐ B.B. or D.B. ☐
VET AFFAIRS No:

DOCTOR'S SIGNATURE AND REQUEST DATE

...../...../.....

COPY REPORTS TO:

HOSPITAL/WARD

REQUESTING DOCTOR

PROVIDER No.:
SURNAME:
INITIALS:
ADDRESS:

Doct						
Copy 1						
Copy 2						
Copy 3						
Hosp/Ward						

Was or will the patient be, at the time of the service or when the specimen is obtained: (✓ appropriate box)

	yes	no
a. a private patient in a private hospital or approved day hospital facility	☐	☐
b. a private patient in a recognised hospital	☐	☐
c. a public patient in a recognised hospital	☐	☐
d. an outpatient of a recognised hospital	☐	☐

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. Alternatively, I authorise that APP to submit my unpaid account to Medicare so that Medicare can assess my claim and issue me a cheque payable to the APP for the Medicare Benefit.

PATIENT'S SIGNATURE AND DATE

X ..... X ...../...../.....

Practitioner's Use Only .....
(Reason patient cannot sign)

PERSON DRAWING BLOOD
I certify that 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).

Signature: .....

LAB USE	Collect Date	Coll. Time	Test Codes	Branch	Ref. No.	Lab. No.	Description & Containers	Collector
	Received Date	Rec. Time	Attachments: Yes / No (please circle) If yes, no. of pages:	B/C	Clinic			

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APA No. 000042 t/a QML Pathology.
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T: (07) 3121 4444 (24hr services) qml.com.au

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TESTS REQUESTED

Learn about your tests
knowpathology.com.au

PATIENT COPY

REQUESTING DOCTOR

PROVIDER No.:
SURNAME:
INITIALS:
ADDRESS:

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 and Ageing or to a person in the medical practice associated with this claim, or as authorised/required by law. For important information regarding your privacy and results visit qml.com.au/privacy.

CLEAR SAVE