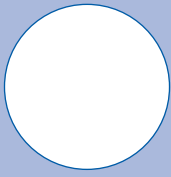


Laboratory use only

<b>Identify</b>	<b>PATIENT DETAILS</b> UR <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>												<b>Patient status at the time of the service or when the specimen was collected.</b> <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td></td> <td><b>Yes</b></td> <td><b>No</b></td> </tr> <tr> <td>(a) a private patient in a private hospital or approved day hospital facility</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>(b) a private patient in a recognised hospital</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>(c) a public patient in a recognised hospital</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>(d) an outpatient of a recognised hospital</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>			<b>Yes</b>	<b>No</b>	(a) a private patient in a private hospital or approved day hospital facility	<input type="checkbox"/>	<input type="checkbox"/>	(b) a private patient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>	(c) a public patient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>	(d) an outpatient of a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>	
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SURNAME ..... GIVEN NAMES ..... DOB ..... / ..... / .....    WARD .....    GENDER .....		Medicare number <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> Expiry date ..... / ..... / .....																												
ADDRESS ..... ..... .....		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. ..... / ..... / ..... Patient's signature ..... Date ..... <b>PRACTITIONERS USE ONLY</b> ..... (Reason patient cannot sign)																												
<b>REQUESTING PRACTITIONER</b> Provider number: .....    Results and Account to: ..... SURNAME & FIRST NAME: Infection Control Consultant .....    Andrea Mattern ADDRESS: .....    PH: (03) 5182 0220 .....    After Hours/On-call ..... .....    PH: 0409 935 506		<b>COPY TO</b> Provider number: ..... SURNAME & FIRST NAME: ..... ADDRESS: ..... .....																												

<b>Situation Background Assessment</b>	<input type="checkbox"/> <b>Urgent</b> – contact laboratory to prioritise.    Precious/irreplaceable specimen requiring confirm receipt on Phone/Pager: .....	
	<b>CLINICAL DETAILS</b> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">                     **CONFIDENTIAL**                 </div> <p style="text-align: center; font-weight: bold; font-size: 1.2em;">                     DO NOT SEND COPY TO WARD                      NEEDLESTICK/BODY FLUID EXPOSURE                 </p>	
		Self Determined <input type="checkbox"/> Fasting: <input type="checkbox"/> OCP: <input type="checkbox"/> HRT: <input type="checkbox"/> Pregnant: <input type="checkbox"/> Gestation: ..... Medication: ..... ..... Dosage: ..... Time: .....
		Histopathology - list previous biopsies including laboratory numbers

<b>Request</b>	<b>TESTS REQUESTED</b> <b>**URGENT**</b> Anti - HIV HBsAG (NSS) Anti - HCV Contact Infection Control Nurse immediately when result is available.	<b>Paediatric samples- list tests in order of priority.</b> ANTIBIOTIC: ..... Spot <input type="checkbox"/> Dose: ..... mg Frequency: daily    BD    Other ..... <b>START</b> administration ..... / ..... / .....    ..... hour <b>FINISH</b> administration ..... / ..... / .....    ..... hour <b>FIRST SAMPLE/SPOT</b> ..... / ..... / .....    ..... hour <b>SECOND SAMPLE</b> ..... / ..... / .....    ..... hour
	Doctor's NAME (print) .....    Sign .....    Date .....    Pager .....    Phone .....    Fax .....	

<b>SPECIMEN TYPE:</b> <input type="checkbox"/> BLOOD <input type="checkbox"/> URINE    OTHER ..... I certify that I collected the specimen accompanying this request from the stated patient whose details I confirmed by direct enquiry and/or examination of their ID wristband and I labelled the specimen immediately after collection in the presence of the patient. <b>SIGNED:</b> .....    Print SURNAME: ..... Date: ..... / ..... / .....    Time: ..... hour	Your treating practitioner has recommended that you use Monash Pathology. You are free to choose your own pathology provider. However, if your treating practitioner has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your treating practitioner.
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