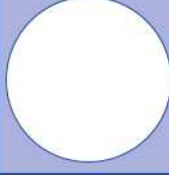




Laboratory use only

Identify	PATIENT DETAILS UR <table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>												Patient status at the time of the service or when the specimen was collected. (a) a private patient in a private hospital or approved day hospital facility <input type="checkbox"/> Yes <input type="checkbox"/> No (b) a private patient in a recognised hospital <input type="checkbox"/> Yes <input type="checkbox"/> No (c) a public patient in a recognised hospital <input type="checkbox"/> Yes <input type="checkbox"/> No (d) an outpatient of a recognised hospital <input type="checkbox"/> Yes <input type="checkbox"/> No		
	SURNAME GIVEN NAMES DOB / / WARD GENDER ADDRESS		Medicare number <table border="1"> <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 / / 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 PRACTITIONERS USE ONLY (Reason patient cannot sign)												
REQUESTING PRACTITIONER Provider number: SURNAME & FIRST NAME: Infection Prevention Nurse ADDRESS: Ph. (03) 5671 3307, 0409 935 506 AH hours - Grade 5 RN (03) 5182 0205		COPY TO Provider number: SURNAME & FIRST NAME: ADDRESS:													
Situation Background Assessment	<input type="checkbox"/> Urgent – contact laboratory to prioritise.		Precious/irreplaceable specimen requiring confirm receipt on Phone/Pager:												
	CLINICAL DETAILS <div style="text-align: center;">**CONFIDENTIAL**</div> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> DO NOT SEND COPY TO WARD NEEDLE STICK/ BODY FLUID EXPOSURE </div> Occupational Exposure Source UR: Unknown/Specify:		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												
Request	TESTS REQUESTED **URGENT** Anti - HBs (HBPV) Contact Infection Control Nurse immediately when result is available.		Paediatric samples- list tests in order of priority. ANTIBIOTIC: Spot <input type="checkbox"/> Dose: mg Frequency: daily BD Other START administration / / hour FINISH administration / / hour FIRST SAMPLE/SPOT / / hour SECOND SAMPLE / / hour												
	Doctor's NAME (print) Sign Date Pager Phone Fax														
SPECIMEN TYPE: <input type="checkbox"/> BLOOD <input type="checkbox"/> URINE <input type="checkbox"/> 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. SIGNED: Print SURNAME: Date: / / Time: hour															
Your treating practitioner has recommended that you use Monash Health 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.															