

ORCPA



Pathology Request Form
Telephone 03 9594 4538 Facsimile 03 9594 6619

Laboratory use only													
										_			
Identify	PATIENT DETAILS UR				or whe	en the spe	cimen was		Yes I	No /			
	2/15/1/15					(a) a private patient in a private hospital or approved day hospital facility (b) a private patient in a recognised hospital							
	SURNAME					(c) a public patient in a recognised hospital (d) an outpatient of a recognised hospital							
					Medicare Expiry date								
	DOB / WARD GENDER					offer to assign my right to benefits to the approved pathology practitioner							
	ADDRESS					determinable service(s) established as necessary by the practitioner.							
						Patient's signature Date PRACTITIONERS USE ONLY							
	REQUESTING PRACTITIONER					COPY TO_ (Reason patient cannot sign)							
	Provider number: Results and Account to:				Provider number:								
	SURNAME & FIRST NAME: Director of Nursing				SURNAME & FIRST NAME:								
	ADDRESS: Ph. 0419 921 908					ADDRESS:							
(i)	AH hours - Exec on-call (03) 5667 5555 Urgent - contact laboratory to prioritise. Precious/irreplaceable specimen requiring confirm receipt on Phone/Pager:												
tuati	CLINICAL DETAILS				•			termined	and the same	sting:			
000	**CONFIDENTIAL**					OCP:							
Bac	DO NOT SEND COPY TO WARD					HRT: Pregnant:							
kgrc	NEEDLE STICK/ BODY FLUID EXPOSURE				Gestation: Medication:								
Background						Dosage:							
As										Time:			
ses										stopath			
essment						Account type Bill payer					list previous biopsies including laboratory		
						KIP		Korbill1	270775465	mbers	V 192		
Request	**URGENT**				i a	Paediatric samples- list tests in order of priority.							
						ANTIBIOTIC: Spot Dose: mg							
	Anti - HIV					Control to the Control of the Contr							
	HBsAg (NSS)					Frequency: daily BD Otherhour							
	Anti-HCV					FINISH administration/ hour							
	Contact Infection Control Nurse immediately when result				FIRST SAMPLE/SPOT/hour								
	is available				SECOND SAMPLE/ hour								
	Doctor's NAME (print)	705-6K			e	Page	г	Phone		Fax			
SPECIMEN TYPE: BLOOD URINE OTHER. I certify that I collected the specimen accompanying this request from the stated national whose details be of invaded by direct enguine and/or experiment.													
	stated patient whose details I confirmed by direct enquiry and/or examination of their ID wristband and I labelled the specimen immediately after collection						ovider.				5		
in the	in the presence of the patient.						However, if your treating practitioner has specified a particular pathologist on clinical grounds, a Medicare rebate will only be						
SIGNED: payable if that pathologist performs the service. You should discuss this with your treating practitioner.													