GOVERNMENT OF WESTERN AUSTRALIA

PathWest LABORATORY MEDICINE WA

Hospital Avenue,Nedlands
Western Australia 6009
ABN 83 469 340 804

CLEAR FORM | SAVE FORM | EMAIL TO PATIENT

RESULTS & ENQUIRIES **13 PATH 7284**

MEDICARE CARD NUMBER*

PATHOLOGY REQUEST

PATIENT Last Name* | Given Name *(including middle initial)** | Sex* | Date of Birth* | Your Reference*

PATIENT Address* | Telephone *(Home)** | Telephone *(Bus)*

Is Patient of Aboriginal Descent? *Please Tick* YES ☐ NO ☐

TESTS REQUESTED*

LABORATORY COPY

Your doctor has recommended that you use PathWest. You are free to choose your own pathology provider. However, if your doctor 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 doctor.

Specified APP: Yes / No
APP Name .....

CLINICAL NOTES

☐ DO NOT SEND REPORTS TO MY HEALTH RECORD

For drug and antibiotic assays (where appropiate). Type(s):

Dose Regimen:

Date of Last Dose:

Time of Last Dose:

Rule 3 Exemption: YES ☐ NO ☐

Self Determine: ..... ☐

URGENT ☐ PHONE ☐ FAX ☐

PHONE/FAX Number .....

Private? ☐ Concession? ☐ Direct Bill? ☐ Vet Affairs Number .....

Doctor's Signature and Request Date*

✗ .....

COPY REPORTS TO

ADDRESS

Send results to HDWA Clinical Information System (iCM) - *See CIS Informed Consent Information Sheet*

Patient: I consent for my results to be stored in the iCM Signature: .....

Requesting Doctor *(Surname, Initials, Provider Number, Address)*

Fasting ☐

Non - Fasting ☐

CERVICO-VAGINAL TESTING

Select reason for test:

1. Routine HPV screen ☐
2. Follow-up HPV test - Last test intermediate risk ☐
3. Co-test (HPV + cytology)
   - (i) Test of cure (post-treatment) ☐
   - (ii) Signs/symptoms
     - Pain ☐
     - Abnormal discharge ☐
     - Abnormal cervix ☐
     - Abnormal bleeding ☐
     - PCB ☐
     - IMB ☐
     - PMB ☐
   - (iii) Recommended in guidelines (immunosuppressed, DES exposed etc.) ☐
4. Cytology following positive self-collected sample ☐
5. Cytology at colposcopy ☐
6. Other .....

Patient Status at Time of Service or When Specimens Collected:

	YES	NO
1. A private patient in a private hospital or approved day hospital facility	☐	☐
2. A private patient in a recognised hospital	☐	☐
3. A public patient in a recognised hospital	☐	☐
4. An outpatient of a recognised hospital	☐	☐

RCPA The Royal College of Pathologists of Australasia

NATA

Date of collection | Time of collection

Collector's Signature *I certify that the blood specimen(s) accompanying this request was drawn from the patient named above and I established the identity of this patient by direct inquiry and/or by inspection of wrist band and immediately upon the blood being drawn I labelled the specimen(s).*

✗ .....

CLOT	CIT	HEP	EDTA	GLU	ESR	OTHER

Medicare Assignment
(Section 20A 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.

Patient's Signature and Date

✗ .....

Practitioner Use Only ..... *(Reason Patient Cannot Sign)* .....

C D I S H N X

SOURCE / HOSPITAL

WARD

BILL TO

Date and Time Specimen Received in Laboratory

PWF 751 17.02.20

GOVERNMENT OF WESTERN AUSTRALIA

PathWest LABORATORY MEDICINE WA

Hospital Avenue, Nedlands
Western Australia 6009
Phone: (08) 6457 3000
ABN 83 469 340 804

RESULTS & ENQUIRIES **13 PATH 7284**

MEDICARE CARD NUMBER

PATIENT Last Name | Given Name *(including middle initial)* | Sex | Date of Birth | Your Reference

PATIENT Address | Telephone *(Home)* | Telephone *(Bus)*

TESTS REQUESTED

PATIENT COPY

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.

Requesting Doctor *(Surname and Initials, Provider Number, Address)*

Patient Status at Time of Service or When Specimens Collected:

	YES	NO
1. A private patient in a private hospital or approved day hospital facility	☐	☐
2. A private patient in a recognised hospital	☐	☐
3. A public patient in a recognised hospital	☐	☐
4. An outpatient of a recognised hospital	☐	☐

Medicare Assignment
(Section 20A 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.

Patient's Signature and Date

✗ .....

PWF751 17.02.20