Medihealth Pathology
Helping you with Health

PATHOLOGY REQUEST

Ph: 02 8608 2070 Fax: 02 8211 5295
www.medihealthpathology.com.au

Medicare Card Number

Barcode

Patient Last Name	Given Names	Sex	Date of Birth	Your Patient's Ref:

Patient Address	Postcode	Tel (Home)	Tel (Other)

Tests Requested

LABORATORY COPY

ThinPrep® and **HPV** tests not meeting criteria are **not** covered by Medicare.

- Fasting
- Non-Fasting
- Pregnant
- Horm Therapy
- LMP
- EDC

Cervical Cytology

Site
- Cervix
- Vaginal Vault
- Endometrium
- Other

- Post Natal
- Post Menopausal
- Radiotherapy
- IUCD
- Abnormal Bleeding

Appearance of Cervix
- Benign
- Suspicious

Not for PAP register

Clinical Notes / Medications

Collection Time

Fasting ☐ Non-Fasting ☐ Diabetic ☐ Thyroxine ℞ ☐ Antithyroid ℞ ☐ Pregnant ☐ Self Determined ☐ Time/Hours Post Dose

LAB USE

Tubes						Urine					Swabs			Slides			Containers			Others
Plain	SST	EDTA	Gluc	Cit	Hep	Bacto	Cyto	24Hr	PCR	Others	Micro	Viral	Chlam	Bacto	PAP	Chlam	Faeces	Semen	Histo	

Urgent ☐ **Phone** ☐ **Fax** ☐ By Time: ________
Phone/Fax No:
Private ☐ **Schedule** ☐ **Medicare** ☐
Veteran Affairs:

Doctor's Signature and Request Date

X .... **Date** ....

Report copy to:

Hospital/Ward

Requesting Practitioner: (Including Surame, Initials, Address, Provider No.)

COLLECTOR DECLARATION

Time

Date

Location

I certify that I have collected the accompanying sample from the above patient whose identity was confirmed by direct inquiry and the specimen was labelled in the patient's presence.

COLLECTOR SIGNATURE

Was or will the patient be at the time of service or when the specimen is obtained

		YES	NO
a)	Private patient in a private hospital or approved day hospital facility	☐	☐
b)	Private patient in a recognised hospital	☐	☐
c)	Public patient in a recognised hospital	☐	☐
d)	Outpatient of a recognised hospital	☐	☐

MEDICARE ASSIGNMENT
(Section 20A of the Health Insurance Act1973)
I offer to assign my rights 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

X .... **Date** ....

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

1. **Please ensure both patient name and date of birth are complete prior to removing label.**
2. **Remove label and attach to specimens.**
3. **If more than three specimens, please record patient details directly on additional containers.**

NAME: D.O.B.

NAME:
D.O.B.:
PULL

NAME:
D.O.B.:
PULL

NAME:
D.O.B.:
PULL

BEND FORM TO REMOVE LABELS

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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 Practitioner: (Including Surame, Initials, Address, Provider No.)

Your doctor has recommended that you use Medihealth Pathology. 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 this service. You should discuss this with your doctor.

Patient's Signature and Date

X .... **Date** ....