St Vincent's Pathology

ST VINCENT'S HOSPITAL SYDNEY LIMITED APA
ABN 77 054 038 872
Victoria Street Darlinghurst NSW 2010
Telephone (02) 8382 9100

This document is issued in accordance with the NATA/RCPA accreditation requirements. Accredited for compliance with ISO 15189 Accreditation No 2115

File No .... Location ....

Family Name ....

Given Name ....

Address ....

....

DOB .... Age .... Sex ....

Phone (H) .... (M) ....

Email* ....

* For contact information only. Results will NOT be issued by email.

Requesting

Provider No

Address

Phone No Fax No

Signature .... Date ....

Copies To ....

....

....

....

....

....

Hospital status of patient at specimen collection or date of service	Yes	No
Private patient in a private hospital or approved day hospital facility	☐	☐
Private patient in a recognised hospital	☐	☐
Public patient in a recognised hospital	☐	☐
Outpatient of a recognised hospital	☐	☐

Billing Instructions: Medicare ☐ DVA ☐ Private ☐ IRN

Medicare No. ☐☐☐☐☐☐☐☐☐☐ ☐

MEDICARE ASSIGNMENT *(Section 20A of the Health Insurance Act 1973)*

Practitioners Use Only

TO BE COMPLETED BY THE PERSON ASSIGNING BENEFITS FOR THE SERVICES ON THIS FORM

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.

.... *(reason patient cannot sign)*

Patient Signature .... Date ___/___/___

Medicare Assignment Patient Copy Requested ☐

Phone/Fax to: ☐ **Urgent**

Clinical History

(include medication details) ☐ SD ☐ Rule 3 Exemption

- ☐ Immunocompromised
- ☐ Known Prostate Cancer
- ☐ Diabetic
- ☐ Thyroid Disease or Therapy
- ☐ Venous Thrombosis
- ☐ Pregnant

Tests Requested

☐ **Fasting**

Nature of Specimen/Site Sampled

Cervical Screening Status: Required information. Tick to specify.

- ☐ **Asymptomatic**
- ☐ **Symptomatic/Specific Population Screening/Follow Up**
- ☐ **Vaginal Vault**
- ☐ **Follow Up on Self Collect HPV Test for Clinical Management**
- ☐ **Repeat due to Unsatisfactory Tests**

Drug Assays

	Dose/Frequency	Commenced (date/time)	Last Dose (date/time)
....	....	....	....
....	....	....	....

Lime	Gold	Blue	4.5ml EDTA	9ml EDTA	Black	Grey	Yellow	Red	Thin Prep	Cyto	Check by
Urine	Faeces	Sputum	Fluid	CSF	Bculture	Swab	Viral sw	PCR Sw	24hrU	Histo	
											Date/Time

PERSON DRAWING BLOOD 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 immediately upon the blood being drawn I labelled the specimen(s). This signature also acknowledges the collection of all other specimens.

Surname (print) .... Signed ....