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PATHOLOGY REQUEST		MEDICARE CARD NUMBER 2745411824 1		
PATIENT SURNAME Wade		GIVEN NAMES Janine	SEX F	DATE OF BIRTH 14/01/1982
PATIENT ADDRESS 46 Sunshine Street Manly Vale, NSW, 2093, AU		TEL M: 0404566722 H: 0404566722		YOUR REF: TEL (BUS)
TESTS REQUESTED HAEMOCHROMATOSIS GENE TESTING PLEASE				Fasting <input type="checkbox"/> Non-Fasting <input type="checkbox"/> Pregnant <input type="checkbox"/> Hormone Therapy <input type="checkbox"/> LNMP <input type="checkbox"/> EDC <input type="checkbox"/> Cervical Cytology Site <input type="checkbox"/> Cervix <input type="checkbox"/> Vaginal Vault <input type="checkbox"/> Endometrium <input type="checkbox"/> Other <input type="checkbox"/> Post Natal <input type="checkbox"/> Post Menopausal <input type="checkbox"/> Radio Therapy <input type="checkbox"/> IUCD <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> Cervix Benign <input type="checkbox"/> Cervix Suspicious <input type="checkbox"/>
CLINICAL NOTES PERSISTENTLY RAISED TF SATURATION, PREVIOUSLY HIGH IRON , ?HFE GENE HETEROZYGOUS / HOMOZYGOUS Site:				DOCTOR SIGNATURE  REQUEST DATE 17/01/2024
URGEN T <input type="checkbox"/> PHONE <input type="checkbox"/> FAX <input type="checkbox"/> BY TIME: PHONE/FAX No: / PRIVATE <input type="checkbox"/> CONCESSION <input type="checkbox"/> BULK BILL <input checked="" type="checkbox"/> VET AFFAIRS No:		DOCTOR SIGNATURE  REQUEST DATE 17/01/2024		
COPY REPORTS TO HOSPITAL/WARD		REQUESTING DOCTOR Dr Damien Ford MBBS, FRACGP Provider No. 5910766T		COLLECTION CENTRE USE

PATIENT STATUS AT TIME OF SERVICE OR WHEN SPECIMEN COLLECTED

1. Private patient in a private hospital or approved day hospital facility

Yes ☐ No ☐

MEDICARE ASSIGNMENT (Sector 20A of the Health Insurance Act 1973)
I assign my right to benefits to the approved practitioner who will render the requested pathology service(s).

PRACTITIONER'S USE ONLY

PATIENT'S SIGNATURE AND DATE


2. Private patient in a recognised hospital

3. a Medicare (public) patient in a recognised hospital

4. Outpatient of recognised hospital

PRIVATE

BULK BILL



This document is issued in accordance with NATA/RCPA accreditation requirements. Accredited Lab Number

(Reason Patient cannot sign)

COLLECTOR TO COMPLETE:

I certify that the blood specimen accompanying this request was drawn from the patient stated as established by direct enquiry of the patient and/or inspection of the ID wrist-band and that specimen was labelled immediately. I have also signed the sample tube(s)

NAME:

SIGN:

TIME:

DATE:

ACC

F

NF

TOLM:

TOLD:

SPECIMENS::

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4. Outpatient of recognised hospital

Yes

No

PRIVATE

BULK BILL

MEDICARE ASSIGNMENT

(Sector 20A of the Health insurance Act 1973)

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PATIENT'S SIGNATURE AND DATE