Pathology Queensland

Queensland Government

Patient Details

HOSPITAL

SEX M F | UR PREFIX | UR NO | DATE OF BIRTH (D D M M Y Y Y Y) | GENDER

PATIENT SURNAME (Please print or place sticker on this area) | PATIENT FIRST NAME

PATIENT ADDRESS | CONTACT NO

Medicare Details

Patient status at the time of the service or when specimen collected (please tick) Yes

- Private patient in a private hospital or approved day hospital facility
- Private patient in a recognised hospital
- Public patient in a recognised hospital
- Outpatient at a recognised hospital
- Bulk Bill Rural & Remote COAG

PHLEBOTOMY USE ONLY

MEDICARE NUMBER

HEALTH FUND NAME | EXP

VETERANS AFFAIRS | IRN

Indigenous status

Aboriginal | TSI | Both | Non-Indigenous | Not stated

MEDICARE ASSIGNMENT FORM (Section 20A of the Health Insurance Act 1973) 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 Signature X | Date / /

PRACTITIONERS USE ONLY (Reason patient cannot sign)

Collector

I certify that I collected the accompanying specimen from the above patient whose identity was confirmed by enquiry and/or examination of their name band and that I labelled the specimen immediately following collection and before leaving the patient.

SURNAME OF COLLECTING PERSON (Please print) | INITIALS

Signature: _____ *Date Collected* ___/___/___ *Time Collected* _____ AM PM

Collection Details

COLLECTION CODE		CONTAINERS COLLECTED (No of Tubes)					
Path QLD Collect Inpatient		EDTA		LHEP		FL OX	
Path Qld Collect Outpatient		SST		EDTA BBANK		URINE	
Ward Collect	Self Collect	RST		BL Culture		SWAB	
Self Collect Assist		CITRATE		ABG		HISTO	
Others							
Patient Fasting							
PEI		OTHER					

REC'D TIME | INITIALS

Pathology Queensland

V131018PU

Unless otherwise stated this form is to be processed by Pathology Queensland as a QLD Health Public Patient.

DOCTORS: Please complete ALL relevant areas in the red section

Request Details

PUBLIC REQUEST FORM | LAB NO

WARD/CLINICAL UNIT | LAB USE ONLY

TEST REQUESTED

CLINICAL NOTES/MEDICATIONS | GESTATIONAL AGE K=

Not for My Health Record ☐

Requesting Officer

CONSULTANT/SENIOR MEDICAL OFFICER SURNAME (Please print) | INITIALS

SURNAME OF REQUESTING OFFICER (Please print) | AUSLAB CODE

FIRST NAME | PROVIDER NUMBER

Requesting Doctor's Signature X | Date Requested / / | Self Determine ☐

URGENT ☐ TEL ☐ PAGE ☐ FAX ☐ | CONTACT NO

Copy

COPY REPORT TO: SURNAME (Please print) | INITIALS

COPY REPORT TO ADDRESS