StV Pathology

MEDICARE CARD NUMBER

PATHOLOGY REQUEST (03) 9288 2888

St. Vincent's Hospital (Melbourne) Ltd APA
t/a St. Vincent's Pathology (ABN 22 052 110 755)
41 Victoria Pde FITZROY 3065
pathologyfeedback@svhm.org.au

SEE OVER FOR COLLECTION CENTRES

A/4323 11/2008 SV 524

PATIENT LAST NAME GIVEN NAMES | SEX | DATE OF BIRTH | YOUR REF:

PATIENT ADDRESS | POSTCODE | TEL(HOME) | TEL(BUS)

TESTS REQUESTED

- Fasting ■
- Non Fasting ■
- Pregnant ■
- Horm Therapy ■
- LNMP ■
- EDC ■
- Cervical Cytology
- Site Cervix ■
- Vaginal Vault ■
- Endometrium ■
- Other ■
- Post Natal ■
- Post Menopausal ■
- Radio Therapy ■
- IUCD ■
- Abnormal Bleeding ■
- Appearance of Cervix Benign ■ Suspicious ■

CLINICAL NOTES

☐ RULE 3 EXEMPTION ☐ SD TICK

URGENT ■ **PHONE** ■ **FAX** ■ BY TIME:
PHONE/FAX No:
PRIVATE ■ CONCESSION ■ BULK BILL ■
DVA (Repat) Number:

DOCTOR'S SIGNATURE AND REQUEST DATE

X ..... X .....

COPY REPORTS TO:

HOSPITAL/WARD

REQUESTING DOCTOR (PROVIDER NUMBER, INITIALS, SURNAME, ADDRESS)

Doct						
Copy 1						
Copy 2						
Copy 3						
Hosp/Ward						

Patient Status at the time of the service or when the Specimen was Collected

	Yes	No
(a) Private Patient in a private hospital or approved day hospital facility	☐	☐
(b) Private patient in a recognised hospital	☐	☐
(c) A public patient in a recognised hospital	☐	☐
(d) Outpatient of a recognised hospital	☐	☐

PATIENT'S SIGNATURE AND DATE

MEDICARE ASSIGNMENT (Section 20A of the 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 practioner.

X ..... X .....

LU AS BE — Collect Date ____ Coll. Time ____ Received Date ____ Rec. Time ____

CC SC HO NH DR PU IP HP OP

PRACTITIONERS USE ONLY

(REASON PATIENT CANNOT SIGN)

Collectors Signature

StV Pathology

PATHOLOGY REQUEST (03) 9288 2888

St. Vincent's Hospital (Melbourne) Ltd APA t/a St. Vincent's Pathology (ABN 22 052 110 755)
41 Victoria Pde FITZROY 3065 pathologyfeedback@svhm.org.au

SEE OVER FOR COLLECTION CENTRES

MEDICARE CARD NUMBER

PATIENT LAST NAME GIVEN NAMES | SEX | DATE OF BIRTH | YOUR REF:

PATIENT ADDRESS | POSTCODE | TEL(HOME) | TEL(BUS)

TESTS REQUESTED

REQUESTING DOCTOR (PROVIDER NUMBER, INITIALS, SURNAME, ADDRESS)

Patient Status at the time of the service or when the Specimen was Collected

	Yes	No
(a) Private Patient in a private hospital or approved day hospital facility	☐	☐
(b) Private patient in a recognised hospital	☐	☐
(c) A public patient in a recognised hospital	☐	☐
(d) Outpatient of a recognised hospital	☐	☐

PATIENT'S SIGNATURE AND DATE

MEDICARE ASSIGNMENT (Section 20A of the 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 practioner.

X ..... X .....