AUSTRALIAN Clinicallabs
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YOUR PATHOLOGY REQUEST

1868 Dandenong Rd, Clayton 3168
Clinical Laboratories Pty Ltd (A.P.A.) A.B.N. 62 006 823 089

Title:	Patient Surname:	Given Names:
Date of Birth:	Sex	Practice UR Number:
Address:		Postcode:
Medicare/Repat Number		

Patient Phone No: N/A

Hospital: UHG

Ward:

REQUESTING DOCTOR, PROVIDER NO. & ADDRESS, SURNAME & INITIALS:

Copies To:

UHGIC - Barwon Health Infection Control
UHG

BILLING CATEGORY

- ☐ MEDICARE
- ☐ PRIVATE
- ☐ REPAT
- ☐ RULE 3 EXEMPTION
- ☐ HEALTH FUND (Specify)_____
- ☐ COMMERCIAL (Specify)_____

HOSPITAL PATIENTS

Patient Status at the time of Service or when the specimen was collected.

	YES	NO
Private patient in a private hospital or approved day hospital facility	☐	☐
Private patient in a recognised hospital	☐	☐
A public patient in a recognised hospital	☐	☐
Outpatient of a recognised hospital	☐	☐

- ☐ Pregnant
- ☐ LNMP
- ☐ Horm Therapy

CYTOLOGY
Site
- ☐ Cervix
- ☐ Vagina/Vault
- ☐ Post - Partum
- ☐ Post Menopause
- ☐ I.U.C.D
- ☐ Abnormal Bleeding
- ☐ Other Please specify:

Appearance
- ☐ Benign
- ☐ Suspicious

Urg ☐ D.E ☐

CLINICAL NOTES

Barwon Health INPATIENTS: COVID & RESP PCR
[*] HIGH Priority - URGENT
Billing Code: V3050

Reorder Code:

Do not send reports to My Health Record ☐

Your doctor has recommended that you use Clinical Laboratories. 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 the service. You should discuss this with your doctor.

Patient Claim - I authorise Clinical Laboratories to submit my unpaid account to Medicare for assessment.

X Patient Signature _____ Date ____/____/____

TESTS REQUESTED: Non Fasting ☐ Fasting ☐

- CVI
- RVH

To be processed in Clayton <24hrs

Reorder Code: UHG_CVI-RVH_Inpatients

DOCTOR'S SIGNATURE COMPULSORY

X _____

DATE ____/____/____

☐ URGENT
- ☐ Phone _____
- ☐ Fax _____
- ☐ Pager _____
- ☐ By_____Hrs

I certify that I collected the accompanying sample from the above patient, whose identity was confirmed by inquiry and/or examination of their name-band, and that I labelled the sample immediately following collection.

PERSON COLLECTING SPECIMEN

Full Name_____ Signature X_____ Date ____/____/____ Time_____

GEL	EDTA	SOD CIT	FL OX	PLAIN	HEP	ESR

24H U	MSU	SWAB	PAP	HIST	SLIDE	FAECE	SPUT

FUNG	SEMEN	CSF	EGG TRACE

HOLT TRACE	OTHER	