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Dorevitch PATHOLOGY

RCPA NATA
The Royal College of Pathologists of Australasia
Accreditation Number 2204
Accredited for compliance with NPAAC standards and ISO 15189

MEDICARE CARD NUMBER – IRN

PATHOLOGY REQUEST

dorevitch.com.au 03 9244 0444
18 Banksia Street Heidelberg Victoria 3084
Results Line 9244 0472

Specialist Diagnostic Services Pty Ltd, ABN 84 007 190 043 APA No. 000042, trading as Dorevitch Pathology

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

TEL (HOME) | TEL (BUS)

TESTS REQUESTED

CLINICAL NOTES

Fasting ☐
Non Fasting ☐
Pregnant ☐
Horm Therapy ☐
LMP ___/___/___
EDC ___/___/___

Cervical Screening
Cervix ☐
Vagina ☐
Self Collect ☐
Post Natal ☐
IUCD ☐
PCB/PMB ☐
Abnormal Bleeding ☐
Cx Suspicious ☐
Previous AIS ☐
Radiotherapy ☐
Immune deficient ☐

GEL	EDTA	Na CIT	FL OX	PLAIN	LIT HEP	Na HEP	ACD	LH GEL	ESR	24h U	MSU	SWAB	PAP	HIST	SLIDE	FAEC	SPUT	FUNG	SEM	CSF / BC	ECG TRACE	HOLT	VIRAL SWAB	THIN PREP	Received by:	No. of Tests:

URGENT ☐ PHONE ☐ FAX ☐ By Date & Time

Ph/Fax No:

PRIVATE ☐ CONCESSION ☐ BULK BILL ☐

VET AFFAIRS No:

☐ RULE 3 EXEMPTON ☐ SD (Self Determined)

Doctor to sign ▶ Dr.

REQUEST DATE

COPY REPORTS TO:

HOSPITAL/WARD

REQUESTING PRACTITIONER Surname & Initials, Address, Tel No.,& Provider No.

PATIENT STATUS AT THE TIME OF THE SERVICE OR WHEN THE SPECIMEN WAS COLLECTED	YES	NO
(a) A PRIVATE PATIENT IN A PRIVATE HOSPITAL, OR APPROVED DAY HOSPITAL FACILITY OR,	☐	☐
(b) A PRIVATE PATIENT IN A RECOGNISED HOSPITAL OR,	☐	☐
(c) A PUBLIC PATIENT IN A RECOGNISED HOSPITAL OR,	☐	☐
(d) AN OUTPATIENT OF A RECOGNISED HOSPITAL	☐	☐

MEDICARE ASSIGNMENT **(Section 20A of the Health Insurance Act 1973)** I offer to assign my right to benefits to the approved pathology practitioner ("APP") who will render the requested pathology services and any eligible pathologist determinable service(s) established as necessary by the practitioner. Patient Account Statement: Your doctor has requested tests on a clinical basis. Some of these may not be eligible for a Medicare rebate, and you may receive an account. For full details refer to Dorevitch Pathology Billing Policy as found on the website. dorevitch.com.au

Patient to sign ▶ X ..... (Patient's Signature) X ..... (Reason patient cannot sign) ...../...../..... (Date)

Specimen Collected
Date / /
Time

Drug - Last Dose
Date / /
Time

Collector to sign ▶ I certify that the pathology specimen(s) accompanying this request was collected from the patient named above and I established the identity of this patient by direct inquiry and/or by inspection of wrist band.

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

Location	C V N H	PR	Fee Cat:
	P O L	PU	

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

TESTS REQUESTED

CLEAR FORM | SAVE

REQUESTING PRACTITIONER Surname & Initials, Address, Tel No., & Provider No.

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Patient to sign ▶ X ..... (Patient's Signature) X ..... (Reason patient cannot sign) ...../...../..... (Date)

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