

MEDICARE CARD NUMBER

PATHOLOGY REQUEST QML PATHOLOGY WARFARIN CONTROL FORM

PATIENT LAST NAME	GIVEN NAMES	SEX	DATE OF BIRTH	QML REF No.
PATIENT ADDRESS		POSTCODE	TEL(HOME)	TEL(BUS)

■ Is this a new postal address or contact phone number since your last test? Yes / No (please circle)

TESTS REQUESTED

QML Pathology Control – PT/INR AS REQUIRED – Rule 3 Exemption Wt: _____ kg Ht: _____ cm
REMEMBER: The preferred time to present for testing is 9am – 12pm

CLINICAL NOTES

Current Warfarin Dose Schedule: Daily _____ mg OR
 Alternate Days _____ / _____ mg OR Other _____

- Last dose of _____ (number of) x _____ mg tablets (strength) = Total of _____ mg. Taken on: ___ / ___ / ___ at _____
- Have you missed or withheld any doses in the last 7 days? (Please circle your responses) Yes / No / Unsure
- Has anyone other than QML Pathology (e.g. your doctor or yourself) changed your dose since last test? Yes / No / Unsure
- Since your last QML test, have you been hospitalised for more than 1 day? Yes / No / Unsure
- Since your last QML test, have you had **any changes** to medication **other than warfarin** for more than 1 day? Yes / No / Unsure
- Since your last QML test, have you had any notable changes to your health? (e.g. weight loss/bleeding/blood clots) Yes / No / Unsure

If yes to any of the above, please specify which medication(s) or changes or reasons – **YOU MUST PROVIDE DATES:**

Date began: ___ / ___ / ___

Date ceased/ceasing: ___ / ___ / ___

■ Other points of note? (e.g. Impending surgery) Yes / No

SELF DETERMINE

FIRST VISIT or NEW to QML CONTROL

- Complete Warfarin Charter of Care & Contact Details Form
- Patient to be advised of initial registration fees

DOCTOR'S SIGNATURE AND REQUEST DATE

FORM/HA/230 Version 4 (683018) _____ / _____ / _____

Rule 3 Expiry Date: _____ / _____ / _____
 Is there a new signed form? Yes / No (please circle)
 If yes than that form is to be used as the original & this form is the attachment

I confirm that the information provided on this form by myself to QML Pathology is based upon accurate responses. I have included any medication changes as prescribed by my doctor. I understand QML Pathology will not be responsible for any adverse medical outcome sustained by me as a consequence of providing QML Pathology with inaccurate information.
 Signature: _____ Date: _____

COPY REPORTS TO:

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

HOSPITAL/WARD

Visit Type:

- Rooms
- Nursing Institution / Care Facility
- Home Visit

HV Booking Number: _____

Was or will the patient be, at the time of the service or when the specimen is obtained: (✓ appropriate box)

- | | | |
|--|--------------------------|--------------------------|
| a. a Private patient in a private hospital or approved day hospital facility | yes | no |
| b. a Private patient in a recognised hospital | <input type="checkbox"/> | <input type="checkbox"/> |
| c. a Public patient in a recognised hospital | <input type="checkbox"/> | <input type="checkbox"/> |
| d. an Outpatient of a recognised hospital | <input type="checkbox"/> | <input type="checkbox"/> |

MEDICARE ASSIGNMENT
(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'S SIGNATURE AND DATE

X _____ X _____ / _____ / _____

Practitioner's Use Only _____
(Reason patient cannot sign)

PERSON DRAWING BLOOD

I certify that the blood specimen(s) accompanying this request was drawn from the patient named above. I established the identity of this patient by direct inquiry and/or by inspection of wrist band and immediately upon the blood being drawn I labelled the specimen(s).

Signature _____

L A S B E	Collect Date	Coll. Time	Test Codes	Attachments Yes / No (please circle) If yes, no. of pages:	Branch	Ref. No.	Lab. No.	Description & Containers	Collector
	Received Date	Rec. Time			B/C	Clinic			

Remember between now and your next test date to contact QML Pathology on **1300 661 963** or email **warfarincare@qml.com.au** if any relevant changes occur:

- Medications Changes, including herbs and vitamins, longer than 3 days
- Significant changes to your health, new medical conditions or health deterioration
 - If warfarin needs adjusting prior to planned procedures/surgery
 - If you have been hospitalised for more than 24 hours

For a full list of our Collection Centres and their opening hours please visit **www.qml.com.au** or call your local QML Pathology Laboratory:

Ballina (02) 6686 6424
Brisbane (07) 3121 4444
Buderim (07) 5441 0200
Bundaberg (07) 4152 8411
Cairns (07) 4051 8944
Emerald (07) 4982 0306
Gladstone (07) 4829 5000
Gympie (07) 5482 1511
Ipswich (07) 3413 3400

Kingaroy (07) 4162 1499
Mackay (07) 4951 2999
Redcliffe (07) 3049 4444
Rockhampton (07) 4921 2155
Southport (07) 5668 4444
Toowoomba (07) 4638 9149
Townsville (07) 4795 6400
Tugun (07) 5631 3022

PRIVACY NOTE:

The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of government health programs, and may be used to update enrolment records. Its collection is authorised by provisions of the Health Insurance Act 1973. The information may be disclosed to the Department of Health and Ageing or to a person in the medical practice associated with this claim, or as authorised/required by law.