

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

TESTS REQUESTED

QML Pathology Control – PT/INR AS REQUIRED – Rule 3 Exemption Wt: _____ kg Ht: _____ cm

PLEASE 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? 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 - If Yes, please give brief details below) Yes No

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: _____

QML PATHOLOGY/DOCTOR USE

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

Visit Type:
 Rooms
 Nursing Institution / Care Facility
 Home Visit
HV Booking Number: _____

DOCTOR'S SIGNATURE AND REQUEST DATE
 FORM/HA/230 Version 5 (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

COPY REPORTS TO:
 HOSPITAL/WARD

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

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
 c. a Public patient in a recognised hospital
 d. an Outpatient of a recognised hospital

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 / /
 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 U S 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				