

**QML REF NO.**

**MEDICARE CARD NUMBER**

**PATHOLOGY REQUEST  
 QML PATHOLOGY WARFARIN  
 CONTROL FORM**

<b>PATIENT LAST NAME</b>		<b>GIVEN NAMES</b>		<b>SEX</b>	<b>DATE OF BIRTH</b>
<b>PATIENT ADDRESS</b>			<b>POSTCODE</b>	<b>TEL(HOME)</b>	<b>TEL(BUS)</b>
■ Is this a new postal address or contact phone number since your last test? <input type="checkbox"/> Yes <input type="checkbox"/> 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**

**COLLECTION STAFF PLEASE ENSURE ALL QUESTIONS ARE ANSWERED (Tick box where appropriate)**

**Current Warfarin Dose Schedule:**

(Complete schedule AND current dose information)

Daily \_\_\_\_\_ mg OR  Alternate Days \_\_\_\_\_ / \_\_\_\_\_ mg OR  Other \_\_\_\_\_

• Last dose of \_\_\_\_\_ (number of) x \_\_\_\_\_ mg tablets (strength) = Total of \_\_\_\_\_ mg. Taken on: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ at \_\_\_\_\_

**Important questions for patient/carer**

- 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 dosed test, have you been hospitalised for more than 1 day?  Yes  No  Unsure
- Since your last QML dosed test, have you had **any changes** to medication **other than warfarin** for more than 1 day?  Yes  No  Unsure
- Since your last QML dosed test, have you had any notable changes to your health? (e.g., weight loss/bleeding/blood clots)  Yes  No  Unsure
- Other points of note (e.g., impending surgery/difficult collect or any relevant information for Warfarin Clinic)  Yes  No
- Is there a form from a doctor attached with any clinical notes?  Yes  No

If 'yes' answered to any of the above, please give brief details, including any medications and/or changes and reasons – **YOU MUST PROVIDE DATES:**

Date began: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date ceased/ceasing: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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: \_\_\_\_\_

For a full list of our collection centres and their opening hours, please visit [www.qml.com.au](http://www.qml.com.au) or call (07) 3121 4100.

**QML PATHOLOGY/DOCTOR USE**

**FIRST VISIT or NEW to QML CONTROL**  
 - After a break of more than 3 months complete Warfarin Charter of Care & Contact Details Form  
 - Patient to be advised of registration fees

**Visit Type:**  
 Rooms  
 Nursing Institution/Care Facility  
 Home Visit  
**HV Booking Number:** \_\_\_\_\_

**DOCTOR'S SIGNATURE AND REQUEST DATE**  
 FORM/HA/230 Version 6 (683018) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Rule 3 Expiry Date:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Is there a new signed form? Yes / No (please circle)  
 If yes, then 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	<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 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 practitioner. In the alternate, I authorise that APP to submit my unpaid account to Medicare so that Medicare can assess my claim and issue me a cheque payable to the APP for the Medicare Benefit.

**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 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			