QML Pathology

RCPA The Royal College of Pathologists of Australasia

NATA ACCREDITED FOR TECHNICAL COMPETENCE

Accredited for compliance with NPAAC Standards and ISO 15189

Accreditation Number: 2184

Specialist Diagnostic Services Pty Ltd (ABN 84 007 190 043) APA No. 000042 t/a QML Pathology.
11 Riverview Place, Metroplex on Gateway, Murarrie Qld 4172. Ph (07) 3121 4444 (24hr services) qml.com.au

MEDICARE CARD NUMBER

PATHOLOGY REQUEST

PATIENT LAST NAME | GIVEN NAMES | MALE / FEMALE / UNKNOWN / OTHER | DATE OF BIRTH | FILE No.

PATIENT ADDRESS | POSTCODE | TEL (HOME & MOBILE) | TEL (BUS)

TESTS REQUESTED

CLINICAL NOTES

LABORATORY COPY

- 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 ☐

☐ SELF DETERMINED

☐ STANDARD PRECAUTIONS ☐ PRIVATE & CONFIDENTIAL ☐ CUMULATIVE REPORT

URGENT ☐ **PHONE** ☐ **FAX** ☐ BY TIME:

PHONE/FAX No:

QML Fee ☐ S.F. ☐ B.B. or D.B. ☐

VET AFFAIRS No:

DOCTOR'S SIGNATURE AND REQUEST DATE

...../...../.....

COPY REPORTS TO:

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

HOSPITAL/WARD

Doct						
Copy 1						
Copy 2						
Copy 3						
Hosp/Ward						

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

		yes	no
a.	a private patient in a private hospital or approved day hospital facility	☐	☐
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 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 inspection of wrist band and immediately upon the blood being drawn I labelled the specimen(s).

Signature.....

LAB USE

Collect Date | Coll. Time | Test Codes | Branch | Ref. No. | Lab. No. | Description & Containers | Collector

Received Date | Rec. Time | Attachments: Yes / No (please circle) If yes, no. of pages: | B/C | Clinic

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CLEAR FORM

SAVE

PATIENT COPY

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

USE OF PATIENT CONTACT INFORMATION ☐ I consent to my contact details (and no clinical information) being used by QML Pathology for marketing communication purposes. PATIENT SIGNATURE X ..... X DATE / /

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.