


A/41/21





**PathWest**  
LABORATORY MEDICINE WA

Hospital Avenue  
Nedlands 6009  
ABN 13 993 250 709  
Metropolitan Health Service APP

**RESULTS & ENQUIRIES**

**3 PATH 7284**

**PATHOLOGY REQUEST**

Unit no. _____ Medicare Number _____ Surname _____ Given Names _____ Date of Birth _____ Age _____ Sex _____ Address _____  <b>TESTS REQUESTED</b> <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <b>URGENT</b> <input type="checkbox"/> <b>PHONE</b> <input type="checkbox"/> <b>FAX</b> <input type="checkbox"/>          Ph / Fax Number: _____       </div>   <b>CLINICAL NOTES</b>   Results to be: <input type="checkbox"/> Fixed <input type="checkbox"/> Phoned	Consultant: _____ Requesting Doctor: _____  Doctor's Signature _____ Request Date: _____ Page: _____ Copy Ref: _____  Fasting: Yes <input type="checkbox"/> No <input type="checkbox"/> Rule 3 Exemption: Yes <input type="checkbox"/> No <input type="checkbox"/> Anticoagulant Therapy Warfarin <input type="checkbox"/> Heparin <input type="checkbox"/>  Patient's Signature for Ancillary Test: _____	Source / Hospital: _____ Ward / Clinic: _____ Day of Collection <table style="width: 100%; text-align: center;"> <tr> <td>M</td><td>T</td><td>W</td><td>Thu</td><td>F</td><td>S</td><td>Su</td> </tr> </table> When collecting ANTIBIOTIC or DRUG assays fill in this box: <table style="width: 100%; text-align: center;"> <tr> <td>Drug</td><td>Dosage</td><td>Date</td><td>Time</td> </tr> <tr> <td>_____</td><td>_____</td><td>_____</td><td>_____</td> </tr> </table> Date of Collection: _____ Time of Collection: _____ <table style="width: 100%; text-align: center;"> <tr> <td>CLOT</td><td>SST</td><td>CIT</td> </tr> <tr> <td>ACD</td><td>HDP</td><td>EDTA</td> </tr> <tr> <td>GLU</td><td>ESR</td><td>ABC</td> </tr> <tr> <td>URINE</td><td>24 URINE</td><td>SWAB</td> </tr> <tr> <td>SLIDE</td><td>Other</td><td></td> </tr> </table> Collector's Signature <i>I certify that the blood specimen(s) accompanying this request was drawn from the patient named above and I established the identity of this patient by direct inquiry under the supervision of a qualified person and immediately upon the blood being drawn I labelled the specimen(s).</i> _____ Patient status at time of service or when specimens collected: <table style="width: 100%;"> <tr> <td>1. A private patient in a private hospital or approved day hospital facility</td> <td style="text-align: right;">Y/N/O</td> </tr> <tr> <td>2. A private patient in a recognised hospital</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>3. A Medicare (public patient) in a recognised hospital</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>4. An outpatients of a recognised hospital</td> <td style="text-align: right;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> </table> <div style="display: flex; justify-content: space-between; align-items: center;">   </div>	M	T	W	Thu	F	S	Su	Drug	Dosage	Date	Time	_____	_____	_____	_____	CLOT	SST	CIT	ACD	HDP	EDTA	GLU	ESR	ABC	URINE	24 URINE	SWAB	SLIDE	Other		1. A private patient in a private hospital or approved day hospital facility	Y/N/O	2. A private patient in a recognised hospital	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	3. A Medicare (public patient) in a recognised hospital	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4. An outpatients of a recognised hospital	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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**NEW ORDERS:**

**Clinic Details:**

Clinic/Hospital Name: \_\_\_\_\_

Ward Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (08) \_\_\_\_\_ Fax: (08) \_\_\_\_\_

**Doctor Details (up to 7 Doctors per pad) :**

- |  |   |
|--|---|
| 1. Dr: _____<br>Provider number: _____<br>Ultra Code: _____<br>3. Dr: _____<br>Provider number: _____<br>Ultra Code: _____<br>5. Dr: _____<br>Provider number: _____<br>Ultra Code: _____<br>7. Dr: _____<br>Provider number: _____<br>Ultra Code: _____ | 2. Dr: _____<br>Provider number: _____<br>Ultra Code: _____<br>4. Dr: _____<br>Provider number: _____<br>Ultra Code: _____<br>6. Dr: _____<br>Provider number: _____<br>Ultra Code: _____ |
|--|---|

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