PathWest LABORATORY MEDICINE WA

Hospital Avenue, Nedlands
Western Australia 6009

ABN 13 993 250 709

RESULTS & ENQUIRIES 13 PATH 7284
Metropolitan Health Service APA

PATHOLOGY REQUEST

PATIENT Last Name | Given Name (including middle initial) | Date of Birth | Sex | Your Reference

Is Patient of Aboriginal Descent? Please Tick Yes ❑ No ❑

PATIENT Address | Unit no. | Telephone

Medicare Assignment (Section 20A 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.
Patient's Signature and Date:
✗ ______ __/__/__

TESTS REQUESTED

URGENT ❑ PHONE ❑ FAX ❑
Ph / Fax Number:

Source / Hospital | Ward

Medicare Number

Date of Collection | Time of Collection

Practitioner's Use Only

(Reason patient cannot sign)

SAMPLE

Collector's Signature

Veterans Affairs? ❑

Your doctor has recommended that you use PathWest. You are free to choose your own pathology provider. However, if your doctor has specified a particular pathologist on clinical grounds a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor.
Specified APP: Yes / No APP Name

CLOT	CIT	HEP	EDTA
GLU	ESR	ABG	URINE
SWAB	SLIDE	Other	

C D I S H N X

Cervical Pathology YES NO
Previous Colposcopy / Surgery
Pregnant / Postpartum
Postmenopausal
Vaginal Discharge
Abnormal Bleeding
Abnormal Cervix
LMP:
Previous Smear:
Contraception or Hormones:

CLINICAL NOTES

Fasting: Yes ❑ No ❑

Rule 3 Exemption: Yes ❑ No ❑

Self Determine ❑

Therapeutic Drugs:
Drug Dosage Date Time

Ancillary Test: ThinPrep ❑ PAPNET ❑

Doctor's Signature and Request Date ✗ ______ __/__/__

Bill to:

Patient's Signature for Ancillary Test:
✗

Requesting Doctor (surname and initials, provider number, address)

Copy Reports to:

Patient status at time of service or when specimens collected: YES NO
1. A private patient in a private hospital or approved day hospital facility ❑ ❑
2. A private patient in a recognised hospital ❑ ❑
3. A public patient in a recognised hospital ❑ ❑
4. An outpatient of a recognised hospital ❑ ❑

Send results to HDWA Clinical Information System (iCM) - See CIS Informed Consent Information Sheet
Patient: consent for my results to be stored in the iCM Signature: ✗

RCPA NATA

Have you ordered PathWest Pathology Request Pads before? ____________

If yes, please e-mail a copy of the form you're currently using to with any changes you require to: requestpads.pathwest@health.wa.gov.au

NEW ORDERS:

Clinic Details:

Clinic Name:______________________________

Address:______________________________

Postal Address:______________________________

Telephone: (08)____________________ **Fax: (08)**____________________

Doctor Details (up to 7 Doctors per pad) :

1. Dr:____________________
   Provider number:____________________
2. Dr:____________________
   Provider number:____________________
3. Dr:____________________
   Provider number:____________________
4. Dr:____________________
   Provider number:____________________
5. Dr:____________________
   Provider number:____________________
6. Dr:____________________
   Provider number:____________________
7. Dr:____________________
   Provider number:____________________

Quantity required (50 request sheets per pad): ____________________

Please e-mail completed form to: requestpads.pathwest@health.wa.gov.au