GOVERNMENT OF WESTERN AUSTRALIA

PathWest LABORATORY MEDICINE WA

Hospital Avenue,Nedlands
Western Australia 6009
ABN 83 469 340 804

RESULTS & ENQUIRIES **13 PATH 7284**

MEDICARE CARD NUMBER*

# PATHOLOGY REQUEST

## URGENT - Plasma Uracil

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

PATIENT Address* | Telephone *(Home)** | Telephone *(Bus)*

Is Patient of Aboriginal Descent? *Please Tick* YES ☐ NO ☐

TESTS REQUESTED*

## Plasma Uracil and Dihydrouracil (DPD deficiency phenotype screen)

**Register Using Code: UDPD**

**SPECIMENS REQUIRED:**
**1 Li Heparin tube (no gel) (dark green 3mL tube) minimum 2mL whole blood.**

Fasting ☐
Non - Fasting ☐

Collection **ONLY** available at PathWest FSH or SCGH, Mon-Fri prior to 3pm.

Patients attending other collection centres or outside these times should be directed to return for collection as detailed above

**Special Instructions:**
Call CSRA supervisor at time of collection. Collect on ice and hand deliver to laboratory **immediately.**

Give specimen directly to CSRA supervisor.

☐ DO NOT SEND REPORTS TO MY HEALTH RECORD

**CLINICAL NOTES – Please complete all fields below:**

- ☐ Pre Fluoropyrimidine treatment (treatment naïve)
- ☐ Previous Fluoropyrimidine treatment
  - – 5FU / Capecitabine (circle one)
  - – date of last treatment --/--/--

URGENT ☐ PHONE ☐ FAX ☐
PHONE/FAX Number .....
Private? ☐ Concession? ☐ Direct Bill? ☐ Vet Affairs Number .....

Doctor's Signature and Request Date*
X .....

COPY REPORTS TO

ADDRESS

Requesting Doctor *(Surname, Initials, Provider Number, Address)*

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

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 | ☐ | ☐ |

RCPA The Royal College of Pathologists of Australasia

NATA

| Date of collection | Time of collection |
|---|---|
| | |

Collector's Signature *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 and/or by inspection of wrist band and immediately upon the blood being drawn I labelled the specimen(s).*
X .....

| CLOT | CIT | HEP | EDTA | GLU | ESR | OTHER |
|---|---|---|---|---|---|---|
| | | | | | | |

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**
X .....

*Practitioner Use Only* ..... *(Reason Patient Cannot Sign)*

C D I S H N X

SOURCE / HOSPITAL

WARD

BILL TO

Date and Time Specimen Received in Laboratory

PWF 751 17.02.20

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## CSRA Laboratory Use Only – MUST BE COMPLETED

Time of receipt of specimen: _____

Received on ice: ☐ YES ☐ NO

Time of centrifugation:_____

Time of freezing:_____

CSRA He signature (receipt):_____

CSRA He signature (centrifugation & freezing):_____

## CSRA Special Instructions

Specimen must be centrifuged, separated into two aliquots, and frozen within 1 hr of collection.