



Pathology Request Pads Order Form - Medicare

Repeat Orders

If you have ordered PathWest request pads before, please email a copy of the form you are currently using, with any changes required, to requestpads.pathwest@health.wa.gov.au

New Orders

Please complete the details below and email your completed form to requestpads.pathwest@health.wa.gov.au

		Hospital Avenue, Nedlands Western Australia 6009 ABN 83 469 340 804		RESULTS & ENQUIRIES 13 PATH 7284		PATHOLOGY REQUEST	
PATIENT Last Name _____ Given Name (including middle initial) _____ Date of Birth _____ Sex _____ Your Reference _____		Is Patient of Aboriginal Descent? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare Assignment (Section 20A Health Insurance Act 1973) (Refer to page 10 for details)		Medicare Number _____	
PATIENT Address _____ Unit no. _____ Telephone _____		Source / Hospital _____ Ward _____		Date of Collect. _____ Time of Collection _____		Practitioner's Use Only (Reason patient cannot sign)	
TESTS REQUESTED		URGENT <input type="checkbox"/> PHONE <input type="checkbox"/> FAX <input type="checkbox"/>		Date of Collect. _____ Time of Collection _____		Veterans Affairs? <input type="checkbox"/>	
Ph / Fax Number: _____		CLOT CIT HEP EDTA		Cytology following positive self-collected sample <input type="checkbox"/>		Cervico-Vaginal Testing	
CLINICAL NOTES		GLU ESR ABG URINE		SWAB SLIDE Other		1. Routine HPV screen <input type="checkbox"/>	
DO NOT SEND REPORTS TO MY HEALTH RECORD <input type="checkbox"/> Self Determine <input type="checkbox"/>		C D I S H N X		Therapeutic Drugs:		2. Follow-up HPV test - last test intermediate risk <input type="checkbox"/>	
Doctor's Signature and Request Date _____		Bill to:		Drug Dosage Date Time		3. Co-test (HPV + Cytology) <input type="checkbox"/>	
Requesting Doctor (surname and initials, provider number, address)		Copy Reports to:		Patient status at time of service or when specimens collected:		(i) Signs/symptoms	
Send results to HDWA Clinical Information System (ICM) - See CIG Informed Consent Information Sheet		Patient: I consent for my results to be stored in the ICM _____ Signature _____		1. A private patient in a private hospital or approved day hospital facility <input type="checkbox"/>		Pain <input type="checkbox"/>	

Clinic Details

Clinic Name			
Address			
Postal Address			
Telephone		Fax	
Doctor Details (up to seven Doctors per pad)			
Doctor Full Name		Provider Number	
Doctor Full Name		Provider Number	
Doctor Full Name		Provider Number	
Doctor Full Name		Provider Number	
Doctor Full Name		Provider Number	
Doctor Full Name		Provider Number	
Doctor Full Name		Provider Number	
Quantity required (50 request forms per pad)			