





PATHOLOGY REQUEST

Unit no. _____ Medicare Number _____ Surname _____ Given Names _____ Date of Birth _____ Age _____ Sex _____ Address _____	Consultant _____	Source / Hospital _____ Ward / Clinic _____																														
	Requesting Doctor <small>(surname and initials, provider number, address)</small>	Day For Collection M T W Thu F S Su																														
TESTS REQUESTED <div style="border: 2px solid orange; padding: 5px; display: inline-block;"> URGENT <input checked="" type="checkbox"/> PHONE <input checked="" type="checkbox"/> FAX <input type="checkbox"/> Ph / Fax Number: _____ </div>	Doctors Signature X _____ Request Date _____ Page _____	When collecting ANTIBIOTIC or DRUG assays fill in this box: Drug Dosage Date Time _____ _____																														
		Date of Collection _____ Time of Collection _____																														
Seated Saline Suppression Test - Post-saline (Time 4 hours) <u>Collection:</u> <ul style="list-style-type: none"> 1 x Green top PST tube (for urgent potassium) 1 x Lavender top EDTA tube (sent to PathWest FSH) <u>PathWest processing instructions:</u> <ul style="list-style-type: none"> Do not create a new order for this request form Use pre-printed labels from "pre-saline" collection to label these samples Green tube for urgent potassium Lavender tube centrifuge, separate and freeze (send to FSH Lab frozen) 	Copy Reports to: _____	<table border="1"> <tr> <td>CLOT</td> <td></td> <td>SST</td> <td></td> <td>CIT</td> <td></td> </tr> <tr> <td>ACD</td> <td></td> <td>HEP</td> <td></td> <td>EDTA</td> <td></td> </tr> <tr> <td>GLU</td> <td></td> <td>ESR</td> <td></td> <td>ABG</td> <td></td> </tr> <tr> <td>URINE</td> <td></td> <td>24 URINE</td> <td></td> <td>SWAB</td> <td></td> </tr> <tr> <td>SLIDE</td> <td></td> <td>Other</td> <td></td> <td></td> <td></td> </tr> </table>	CLOT		SST		CIT		ACD		HEP		EDTA		GLU		ESR		ABG		URINE		24 URINE		SWAB		SLIDE		Other			
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CLINICAL NOTES Please phone urgent potassium result to: _____ ? Primary Hyperaldosteronism Completion bloods (Time 4 hours)	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"/>	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 and/or by inspection of wrist band and immediately upon the blood being drawn I labelled the specimen(s).</i> X _____																														
Results to be: <input type="checkbox"/> Faxed _____ <input type="checkbox"/> Phoned _____	Patient's Signature for Ancillary Test: X _____	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 <input type="checkbox"/> <input type="checkbox"/> 2. A private patient in a recognised hospital <input type="checkbox"/> <input type="checkbox"/> 3. A Medicare (public patient) in a recognised hospital <input type="checkbox"/> <input type="checkbox"/> 4. An outpatient of a recognised hospital <input type="checkbox"/> <input type="checkbox"/>																														
		  PWF501 12/19 