Return via Fax:
Att: Clerical Officer
Fax: +61 (0)8 6457 4029
Phone: +61 (0)8 6383 4234
Return via Email:
DiagnosticGenomicsQE.PathWest@health.wa.gov.au

Return via Post:
Department of Diagnostic Genomics
PathWest Laboratory Medicine WA
Level 2, PP Block, QEIIMC
Locked Bag 2009
Nedlands WA 6909

PathWest LABORATORY MEDICINE WA

PLEASE COMPLETE AND RETURN
(FIELDS MARKED* ARE MANDATORY)

Date Returned: _____ **Pages (if Faxed):** _____ *(Including Attachments)*

Returned By: _____ **Phone Number:** _____

Institution: _____ **Fax Number:** _____

TESTING DETAILS

Patient Surname:* _____ **Patient DOB:*** _____

Patient Forename:* _____ **Patient Gender:*** _____

Referring Sample No:* _____ **Requesting Clinician:*** _____

Referring Laboratory:* _____ **Clinician Institution:*** _____

Test(s) Requested:* _____ **Test Cost(s):*** **$AU** _____

(list one per line) _____ *(incl. GST if required)* **$AU** _____

_____ **$AU** _____

_____ **$AU** _____

Total Cost of Above Test(s):* **$AU** _____

BILLING DETAILS

☐ **DO NOT PROCEED WITH TESTING** *(Please provide details of the party responsible for cancelling the above testing)*

Authorising Officer:* _____ **Institution:*** _____

☐ **HEALTH INSTITUTION / CLINICIAN TO BE INVOICED** *(Please provide details of the party to be invoiced for the above testing)*

Please note the full contact details of the party to be invoiced for the above testing:

Contact Name:* _____ **Billing Institution:*** _____

Phone Number:* _____ **Postal Address:*** _____

Fax Number:* _____ **Suburb & Postcode:*** _____

Email Address:* _____ **State & Country:*** _____

☐ **PATIENT/GUARDIAN TO BE INVOICED** *(Testing CANNOT be claimed via Medicare. Your patient must pay for the above testing in full)*

I*, _____ (PRINT PATIENT/GUARDIAN NAME) ***consent to pay the total cost of the requested test(s) listed above,***

up to but not exceeding a total amount of $AU* _____ (TOTAL COST) ***I am aware that this amount cannot be claimed via Medicare.***

Signature of Patient/Guardian*: _____ (PATIENT/GUARDIAN SIGNATURE)

Contact Name:* _____ **Postal Address:*** _____

Phone Number:* _____ **Suburb & Postcode:*** _____

Fax Number:* _____ **State & Country:*** _____

Email Address:* _____