GOVERNMENT OF WESTERN AUSTRALIA

PathWest LABORATORY MEDICINE WA

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? Please Tick Yes ❑ No ❑

PATIENT Address | Unit no. | Telephone

TESTS REQUESTED

URGENT ❑ PHONE ❑ FAX ❑

Ph / Fax Number: _____

RHD NIPT
Panel: GRHD

Note specific sample type required:

- 10mL peripheral blood, collected in BD Paxgene Blood cffDNA tube (available through PathWest)

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 _____

CLINICAL NOTES

RhD negative mother

Fasting: Yes ❑ No ❑

Rule 3 Exemption: Yes ❑ No ❑

Self Determine ..... ❑

Mandatory to complete:

1. **EDD _____ (only accepted between 20-32 weeks gestation)**
2. **Multiple pregnancy No / Yes (Number of fetuses _____)**
3. **Body mass index (BMI) _____**

DO NOT SEND REPORTS TO MY HEALTH RECORD ❑

Doctor's Signature and Request Date ✗ _____ _____/_____/_____

Requesting Doctor (surname and 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 ✗ _____

Source / Hospital | Ward

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).

✗ _____

CLOT	CIT	HEP	EDTA
GLU	ESR	ABG	URINE
SWAB	SLIDE	Other	

C D I S H N X

Therapeutic Drugs:

Drug	Dosage	Date	Time
.....	.....	.....	.....
.....	.....	.....	.....

Bill to:

Copy Reports to:

Medicare Assignment (Section 20A Health Insurance Act1973) 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:

✗ _____ ____/____/____

Medicare Number

_____/

Practitioner's Use Only
(Reason patient cannot sign)

Veterans Affairs? ❑

Cervico-Vaginal Testing
SELECT REASON FOR TEST

1. Routine HPV screen ❑
2. Follow-up HPV test - last test intermediate risk ❑
3. Co-test (HPV + Cytology)

(i) Test of cure (post-treatment) ❑

(ii) Signs/symptoms
- Pain ❑
- Abnormal discharge ❑
- Abnormal cervix ❑
- Abnormal bleeding
  - PCB ❑
  - IMB ❑
  - PMB ❑

(iii) Recommended in guidelines (immunosuppressed, DES exposed etc.) ❑

4. Cytology following positive self-collected sample ❑
5. Cytology at colposcopy ❑
6. Other _____

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

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