



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

PATIENT Address _____ Unit no. _____ Telephone _____

TESTS REQUESTED

RHD NIPT
Panel: GRHD

URGENT PHONE FAX

Ph / Fax Number: _____

Note specific sample type required:

- 10mL peripheral blood, collected in BD Paxgene Blood ccfDNA 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

Mandatory to complete:

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

DO NOT SEND REPORTS TO MY HEALTH RECORD

Fasting: Yes No

Rule 3 Exemption: Yes No

Self Determine

Doctor's Signature and Request Date **X** _____ / _____ / _____

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 **X** _____

Is Patient of Aboriginal Descent? Please Tick Yes No

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).

X _____

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 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 _____ / _____ / _____

Medicare Number _____

Practitioner's Use Only (Reason patient cannot sign)

Veterans Affairs?

Cervico-Vaginal Testing

SELECT REASON FOR TEST

- Routine HPV screen
- Follow-up HPV test - last test intermediate risk
- 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.)

- Cytology following positive self-collected sample
- Cytology at colposcopy
- Other _____

Patient status at time of service or when specimens collected:

- A private patient in a private hospital or approved day hospital facility YES NO
- A private patient in a recognised hospital
- A public patient in a recognised hospital
- An outpatient of a recognised hospital

