GOVERNMENT OF WESTERN AUSTRALIA

PathWest LABORATORY MEDICINE WA

Diagnostic Genomics
2nd Floor, PP Block
Hospital Avenue, Nedlands
Western Australia 6009
ABN 83 469 340 804

ENQUIRIES
(08) 6383 4234

PREGNANCY LOSS
GENOMIC TEST REQUEST FORM

Lab No. (PathWest)

PATIENT Last Name | Given Name (including middle initial) | Date of Birth | Sex

use patient label if available

PATIENT Address

Unit no. | Your reference

TEST(S) REQUESTED

Please write below the test(s) required
Important - please indicate gestation in Clinical Summary

CLINICAL SUMMARY

Gestation at time of fetal loss: _____weeks

Gravida: _____

Parity: _____

[ ] Singleton pregnancy

[ ] Multiple Fetuses? Number: _____

[ ] IVF

[ ] Previous miscarriage(s)? Number? _____

[ ] Known familial genetic abnormality?

[ ] History of miscarriages in other family members?

[ ] Previous child/children with major congenital defects / severe intellectual impairment?

SPECIMEN TYPE

Tissue source

[ ] Placental
[ ] Fetal tissue (please specify)
[ ] Amniotic fluid
[ ] Indeterminate

Tissue state

[ ] Fresh
[ ] Macerated (moderate)
[ ] Macerated (severe)

Consultant

Requesting Doctor

Provider No. _____
Phone No. _____
Fax No. _____
Location _____

Doctor's Signature / Request Date

✗ _____ ___/___/___

Copy Reports to:

Fax No. _____
(required to receive report copy)

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 _____

Patients referred by GPs and private patients must complete the Medicare Assignment details below.

To comply with Privacy Act requirements, these patients must also provide consent for genomic test results to be entered into the iCM (see below).

Results to HDWA Clinical Information System (iCM)

See CIS informed Consent Information Sheet.

Patient Signature

I consent for my results to be stored in the iCM.

✗ _____

Patient status at time when specimens collected:

	Y	N
A private patient in a private hospital or approved day hospital facility	☐	☐
A private patient in a recognised hospital	☐	☐
A public patient in a recognised hospital	☐	☐
An outpatient of a recognised hospital	☐	☐

Bill to:

Medicare Number:

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 / Date

✗ _____ ___/___/___

Practitioner's Use Only
(Reason patient cannot sign)

COLLECTOR'S SIGNATURE

I certify that the fetal specimen was obtained from the mother named on this form.

✗ _____ Date: _____/_____/_____ Time: _____

NATA WORLD RECOGNISED ACCREDITATION

RCPA The Royal College of Pathologists of Australasia