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MOLECULAR TYPING
REQUEST FORM

Laboratory use only: PW No

Referring authority / address for report		
Name (Person):	Organisation:	
Address:		
Postcode:	Phone No:	Email address:
Signed (Requestor/Delegate)		

Submitter (if not as above)		
Name (Person):	Organisation:	
Address:		
Postcode:	Phone No:	Email address:

Billing information (please provide)		
Entity:	Contact Name:	Position
Email address:	Phone No:	
Cost centre (WA Health only):	Authorised by:	

Reason to Test

Brief Background or Clinical Details

Specimen(s)/Isolate(s)									
No	**PathWest Lab No.** *(if known)*	**Submitter ID**	**Organism Genus/Species/Serotype**	**Patient Surname**	**Patient Given Name**	**Patient Birthdate**	**Sample Source/Site**	**Sample Collection Date**	**Sample Type**
1									Select
2									Select
3									Select
4									Select
5									Select
6									Select
7									Select

Please note: Ensure as much information as possible is documented. Copy table to additional pages if required.

PathWest use only:				
Date Received	Total Samples Received	Documentation and Samples Match ☐	Meets Specimen Acceptance Criteria ☐	PathWest Receiving Staff Initials