GOVERNMENT OF WESTERN AUSTRALIA

PathWest LABORATORY MEDICINE WA

Paediatric and Perinatal Pathology
Perth Children's Hospital
Hospital Avenue, Nedlands
Western Australia 6009
ABN 83 469 340 804

ENQUIRIES
(08) 6456 3296

POC PROCESSING REQUEST

SOFT No.

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

PATIENT Address	Unit no.	Your Reference
use patient label if available		

GESTATION:

MANDATORY INFORMATION

Requesting Doctor: _____

Provider Number: _____

Surname, Initials: _____

Address: _____

_____

_____

Phone Number: _____

Signature: _____

Date: _____

PLEASE COMPLETE SECTION A AND B

SOURCE / HOSPITAL

_____

WARD

_____

FIN. ELEC: PUB

Section A: Examination / Testing Required

[ ] No Histological Examination Required

[ ] Histological Examination
Clinical indication for histological examination (e.g. Missed Miscarriage, recurrent miscarriage, signs of sepsis or suspicion of molar disease);

Please note: If ancillary testing such as genetics is required, please complete the correct PathWest request form and send fresh tissue directly to PathWest Diagnostic Genomics.

Copy Reports to:

Fax No:

_____
(required to receive report copy)

Section B: Disposal / Cremation

[ ] Respectful Cremation Only (No forms or consent required)

[ ] Cremation Consented (Please attach completed NCC3b form).

COLLECTOR'S SIGNATURE

I certify that the specimen was obtained from the mother named on this form. I established her identity by direct inquiry and/ or inspection of the wrist band. I labeled the samples immediately after collection. The mother has verified that her name and date of birth on all specimen containers are correct.

X

Date: ____ / ____ / ____ Time: _____

[ ] HIGH RISK
(Blood borne infection)

[ ] URGENT

RCPA The Royal College of Pathologists of Australasia

NATA