SydPath
ST VINCENT'S PATHOLOGY

St Vincents Hospital
Victoria St Darlinghurst NSW 2010
Telephone 02 8382 9100
ST VINCENT'S HOSPITAL SYDNEY LIMITED APA
ABN 77 054 038 872

RCPA The Royal College of Pathologists of Australasia
NATA ACCREDITED FOR TECHNICAL COMPETENCE

This document is issued in accordance with the NATA/RCPA accreditation requirements.
Accredited for compliance with NPAAC Standards and ISO 15189 Accreditation No 2115

MEDICARE CARD NUMBER

PATHOLOGY REQUEST

PATIENT LAST NAME *GIVEN NAMES* *SEX* *DATE OF BIRTH* *FILE No.*

Male

PATIENT ADDRESS *TEL (HOME/MOBILE)* *TEL (BUS)*

TESTS REQUESTED

DO NOT SEND REPORTS TO MY HEALTH RECORD ☐

Fasting
Non Fasting
Pregnant
Weeks Pregnant:
LNMP
EDC

CLINICAL NOTES ☐ *SD*

Lime	Gold	Blue	4.5ml EDTA	9ml EDTA	Black	Grey	Yellow	Red	Thin Prep	Cyto	Urine	Faeces	Sputum	Fluid	CSF	Bculture	Swab	Viral sw	PCR Sw	24hrU	Histo	Check by

URGENT ***PHONE*** ***FAX*** *BY TIME:*

PHONE/FAX No:

Private *Other* *D.B.*

VET AFFAIRS No:

DOCTOR'S SIGNATURE AND REQUEST DATE

Cervical Screening Status:

Required information.
Tick to specify.

- ☐ **Asymptomatic**
- ☐ **Symptomatic/ Specific Population Screening/Follow Up**
- ☐ **Vaginal Vault**
- ☐ **Follow Up on Self Collect HPV Test for Clinical Management**
- ☐ **Repeat due to Unsatisfactory Tests**

COPY REPORTS TO:

HOSPITAL/WARD

REQUESTING DOCTOR (SURNAME, INITIALS, ADDRESS, PROVIDER NUMBER)

PERSON DRAWING BLOOD 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 immediately upon the blood being drawn I labelled the specimen(s). This signature also acknowledges the collection of all other specimens.

Surname (print)_____ Signed _____

Date/Time

MEDICARE ASSIGNMENT *(Section 20A of the Health Insurance Act 1973)*
TO BE COMPLETED BY THE PERSON ASSIGNING BENEFITS FOR THE SERVICES ON THIS FORM
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 Signature _____

Practitioners Use Only

_____
(reason patient cannot sign)

_____/_____/_____

Hospital status of patient at specimen collection or date of service

	Yes	No
- Private patient in a private hospital or approved day hospital facility	☐	☐
- Private patient in a recognised hospital	☐	☐
- A public patient in a recognised hospital	☐	☐
- Outpatient of a recognised hospital	☐	☐

PATHOLOGY REQUEST PATIENT COPY

LIFT LIFT LIFT

SEAL FOR TAMPER EVIDENCE

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Private patient in a private hospital or approved day hospital facility	☐	☐
Private patient in a recognised hospital	☐	☐
Medicare (public) patient in a recognised hospital	☐	☐
Outpatient of a recognised hospital	☐	☐

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