ST VINCENT'S PATHOLOGY

Your doctor has recommended that you use St. Vincent's Pathology You are free to use 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.

MEDICARE CARD NUMBER

PATHOLOGY REQUEST (03) 9231 2888

St. Vincent's Hospital (Melbourne) Ltd APA
t/a St. Vincent's Pathology (ABN 22 052 110 755)
41 Victoria Pde FITZROY 3065
pathologyfeedback@svha.org.au

SEE OVER FOR COLLECTION CENTRES

08/2016 SV 524

PATIENT LAST NAME GIVEN NAMES | SEX | DATE OF BIRTH | YOUR REF:

PATIENT ADDRESS | POSTCODE | TEL(HOME) | TEL(BUS)

TESTS REQUESTED

LABORATORY COPY

CLINICAL NOTES

☐ RULE 3 EXEMPTION ☐ SD TICK

URGENT ■ **PHONE** ■ **FAX** ■ BY TIME:
PHONE/FAX No:
PRIVATE ■ CONCESSION ■ BULK BILL ■
DVA (Repat) Number:

DOCTOR'S SIGNATURE AND REQUEST DATE
X ..... X .....

- Fasting ■
- Non Fasting ■
- Pregnant ■
- Horm Therapy ■
- LNMP ■
- EDC ■
- Cervical Cytology
- Site Cervix ■
- Vaginal Vault ■
- Endometrium ■
- Other ■
- Post Natal ■
- Post Menopausal ■
- Radio Therapy ■
- IUCD ■
- Abnormal Bleeding ■
- Appearance of Cervix Benign ■ Suspicious ■

COPY REPORTS TO:

HOSPITAL/WARD

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

Work Place Origin

Patient Status at the time of the service or when the Specimen was Collected	Yes	No
(a) Private Patient in a private hospital or approved day hospital facility	☐	☐
(b) Private patient in a recognised hospital	☐	☐
(c) A public patient in a recognised hospital	☐	☐
(d) Outpatient of a recognised hospital	☐	☐

PATIENT'S SIGNATURE AND DATE

MEDICARE ASSIGNMENT (Section 20A of the 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 practioner.

X ..... X .....

LAB USE: Collect Date | Coll. Time | Received Date | Rec. Time

CC SC HO NH DR PU IP HP OP

PRACTITIONERS USE ONLY

(REASON PATIENT CANNOT SIGN)

Collectors Signature

I certify that the speciemen/s accompanying this request was collected from the patient stated above as established by direct enquiry and/or inspection of wrist band

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