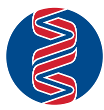

CLINIPATH PATHOLOGY

310 Selby Street North
Osborne Park WA 6017
Telephone: 9371 4200

MEDICARE CARD NUMBER

F116 09/20 A4 REQ

PATIENT SURNAME	GIVEN NAMES	SEX	DATE OF BIRTH	
ADDRESS			TEL (HOME)	TEL (BUSINESS)

TESTS REQUESTED

LSH
TH
Testosterone
Vit D
Karyotype

HIV/HBV/HCV/Syphilis serology
FVU PCR Chlam/gono/ureaplasma/mycoplasma

LABORATORY COPY

FASTING ☐
RANDOM ☐
Pregnant ☐
Hormone Therapy ☐
LNMP
EDC

FOR CST

Site Cervix ☐
Vaginal vault ☐
Endometrium ☐
Other ☐
Post Natal ☐
Post Menopausal ☐
Radio Therapy ☐
IUCD ☐
Abnormal Bleeding ☐
Cervix Benign ☐
Cervix Suspicious ☐

CLINICAL NOTES

Male Fertility work up.

☐ SD (Self Determine)

PATIENT ADVISORY STATEMENT Practitioner to tick if Clinipath Pathology required ☐
Your doctor has recommended that you use Clinipath Pathology. 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.

URGENT! ☐ Phone ☐ Fax ☐ By time:
Phone/Fax no
Private ☐ Schedule ☐ Bulk Bill ☐ ☐ PEN ☐ HCC
Vet Affairs no

DOCTORS SIGNATURE REQUEST DATE

COPY TO

P6021
Oasis Fertility Clinic

REQUESTING DOCTOR
Surname, Initials, Address and Provider Number

COLLECTION CENTRE USE

Hospital status State the patient's status at the time of service or when the specimen was collected: ☐ a private patient in a private hospital ☐ a private patient in a recognised hospital.

TRANSFUSION Hospital: ______
Date required: Time:
Reason for transfusion:
In the last three months has the patient been: Pregnant? ☐ YES ☐ NO
Transfused: ☐ YES ☐ NO

COLLECTOR TO COMPLETE:
I certify that the blood specimen accompanying this request was drawn from the patient stated as established by direct enquiry and/or inspection of the ID wrist-band, and the specimen was labelled immediately. I have also signed the sample tube(s).
NAME: ______
SIGN: ______
TIME: ______ DATE: ______

[ ] SST [ ] EDTA [ ] GLU [ ] CIT
[ ] SNG [ ] PNG [ ] ACD [ ] PPT
[ ] HISTO [ ] PAP [ ] TP [ ] URIN
[ ] SWAB [ ] FAEC [ ] SPUT [ ] OTHER

RCPA NATA
Accredited for compliance with NPAAC Standards and ISO 15189
Clinipath Pathology Pty Ltd trading as Clinipath Pathology and Bunbury Pathology, ABN 57 008 811 185, a subsidiary of Sonic Healthcare Limited (APA) ABN 24 004 196 909, 14 Giffnock Ave, Macquarie Park NSW 2113

MEDICARE ASSIGNMENT (Section 20A of the Health insurance Act 1973)
I assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s)
Practitioner Use Only: ______
(Reason Patient cannot sign)

PATIENT'S SIGNATURE AND DATE
X ______/____/______

CLINIPATH PATHOLOGY

310 Selby Street North
Osborne Park WA 6017
Telephone: 9371 4200

MEDICARE CARD NUMBER

PATIENT SURNAME	GIVEN NAMES	SEX	DATE OF BIRTH	SURGERY FILE #
ADDRESS			TEL (HOME)	TEL (BUSINESS)

TESTS REQUESTED

REQUESTING DOCTOR (Surname, Initials, Address and Provider No.)

PATIENT COPY

Hospital status at the time of service or when the specimen was obtained:

	YES	NO
Private patient in a private hospital / approved day hospital	☐	☐
Private patient in a recognised hospital	☐	☐
Public patient in a recognised hospital	☐	☐
Outpatient of a recognised hospital	☐	☐

MEDICARE ASSIGNMENT (Section 20A of the health insurance Act 1973)

By this declaration I assign my right to benefits to the approved pathology Practitioner who will render the requests pathology service(s). I declare that none of the services claimed in this form relate to an accident, injury or illness which has, or may result in the payment of compensation or damages

PATIENT SIGNATURE AND DATE
..../................/................