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

FBC
Iron studies
Blood group
TSH
Vitamin D
Hormonal profile
Androgen studies
AMH
Ca125

Karyotype
ANA
HbA1c
Rubella/Varicella serology
HIV/HBV/HCV/Syphilis serology
SOLVS PCR Chlam/gono/Ureaplasma/mycoplasma
3 panel RCS (if not previously ordered)

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

Female Fertility work up. Do on Day 2-5 of menstrual cycle.

NOTE: AMH is not covered by Medicare. The Patient will be billed for this test.

☐ 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

REQUESTING DOCTOR
Surname, Initials, Address and Provider Number

COLLECTION CENTRE USE

P6021
Oasis Fertility Clinic

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 The Royal College of Pathologists of Australasia | 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)

PATIENT'S SIGNATURE AND DATE

Practitioner Use Only: _____
(Reason Patient cannot sign)

✗ _____/_____/_____

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.)

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

...../...../.....