virtus DIAGNOSTICS

PATHOLOGY REQUEST

Tel 1800 837 284

virtusdiagnostics.com.au

Medicare Card Number

LAB ID

Patient Last Name	Given Names	Sex	Date of Birth	Your Patient's Ref:

Patient Address	Postcode	Tel (Home)	Tel (Other)

Tests Requested

LABORATORY COPY

ThinPrep® and **HPV** tests not meeting criteria are **not** covered by Medicare.

Clinical Notes

Collection Time

Time/Hours Post Dose

Fasting ☐ Non-Fasting ☐ Diabetic ☐ Thyroxine Rx ☐ Antithyroid Rx ☐ Pregnant ☐ Self Determined ☐

Urgent ☐ **Phone** ☐ **Fax** ☐ By Time: _____

Phone/Fax No:

Private ☐ **Schedule** ☐ **Rebate** ☐ **Bulk Bill** ☐

Veteran Affairs:

IMPORTANT

Global ☐

Doctor's Signature and Request Date

X..... DATE .....

- Fasting ☐
- Non-Fasting ☐
- Pregnant ☐
- Horm Therapy ☐
- LMP ☐
- EDC ☐

Cervical Cytology

Site: Cervix ☐ Vaginal Vault ☐ Endometrium ☐ Other ☐

- Post Natal ☐
- Post Menopausal ☐
- Radiotherapy ☐
- IUCD ☐
- Abnormal Bleeding ☐

Appearance of Cervix

Benign ☐ Suspicious ☐

- Not for PAP register ☐

LAB USE

Tubes						Urine					Swabs			Slides			Containers			Others
Plain	SST	EDTA	Gluc	Cit	Hep	Bacto	Cyto	24Hr	PCR	Others	Micro	Viral	Chlam	Bacto	PAP	Chlam	Faeces	Semen	Histo	

Report copy to:

Hospital/Ward

Requesting Practitioner: (Including Family Name, Initials, Address, Provider No.)

COLLECTOR DECLARATION

Time

Date

Location

I certify that I have collected the accompanying sample from the above patient whose identity was confirmed by direct inquiry and the specimen was labelled in the patient's presence.

COLLECTOR SIGNATURE

Was or will the patient be at the time of service or when the specimen is obtained

	YES	NO
a) Private patient in a private hospital or approved day hospital facility	☐	☐
b) Private patient in a recognised hospital	☐	☐
c) Public patient in a recognised hospital	☐	☐
d) Outpatient of a recognised hospital	☐	☐

MEDICARE ASSIGNMENT

(Section 20A of the Health Insurance Act1973)

I offer to assign my rights 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's Signature and Date

X..... DATE .....

Practitioner's Use Only:

(Reason patient cannot sign.) .....

1. **Please ensure both patient name and date of birth are complete prior to removing label.**
2. **Remove label and attach to specimens.**
3. **If more than three specimens, please record patient details directly on additional containers.**

NAME: D.O.B.

NAME: D.O.B.

NAME: D.O.B.: PULL

NAME: D.O.B.: PULL

NAME: D.O.B.: PULL

BEND FORM TO REMOVE LABELS

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This document is issued in accordance with the NATA/RCPA accreditation requirements. Accredited laboratory 14472.

The Royal College of Pathologists of Australasia

Medicare Card Number

Patient Last Name	Given Names	Sex	Date of Birth	Your Patient's Ref:

Patient Address	Postcode	Tel (Home)	Tel (Other)

Tests Requested

PATIENT COPY

PRIVACY NOTE

The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of government health programs, and may be used to update enrolment records. Its collection is authorised by provisions of the Health Insurance Act 1973. The information may be disclosed to the Department of Health and Ageing or to a person in the medical practice associated with this claim, or as authorised/required by law."

Requesting Practitioner

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	YES	NO
a) Private patient in a private hospital or approved day hospital facility	☐	☐
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X..... DATE .....

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A MEMBER OF VIRTUS HEALTH

Your doctor has recommended that you use Virtus Diagnostics. 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.

For locations and opening times, please visit www.virtusdiagnostics.com.au/collection-centres