MonashPathology
MonashHealth (APA)

Pathology Request Form
Telephone 03 9594 4538 Facsimile 03 9594 6619

RCPA · NATA

Laboratory use only

Minimum three approved patient identifiers
- UR number/Full name/DOB

PATIENT DETAILS UR 9 9 9 9 9 9

SURNAME TESTING

GIVEN NAMES Fred Lee

DOB 21 / 01 /1901 WARD 32S GENDER M

ADDRESS 246 Clayton Road
Clayton, Victoria. 3168

Clinic/ Ward

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		X
b) a private patient in a recognised hospital		X
c) a public patient in a recognised hospital	X	
d) an outpatient of a recognised hospital		X

Medicare number 1 2 3 4 5 6 7 8 9 0 5 Expiry date 09 / 14

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's signature .... Date 1 / 2 / 14

Requesting doctor's, full name and provider number or practice location/address
- JMO use consultant's details

REQUESTING PRACTITIONER

Provider number: 1234567X

SURNAME & FIRST NAME: CITIZEN, John

ADDRESS: 135 David St. Dandenong
Victoria 3175

COPY TO

Provider number: 0123456Y

SURNAME & FIRST NAME: DOE, Jane

ADDRESS: 140-154 Sladen St.
Cranbourne Vic, 3977

Copy to doctor's details, if applicable

X **Urgent** – contact laboratory to prioritise.

Precious/irreplaceable specimen requiring confirm receipt on Phone/Pager: ....

Specimen status, if applicable

CLINICAL DETAILS

Post-surgery
Syncope, emesis

Relevant Clinical details

Fasting: ☐
OCP: ☐
HRT: ☐
Pregnant: ☐
Gestation: ....
Medication: ....
Dosage: ....
Time: ....

Histopathology - list previous biopsies including laboratory numbers

EXAMPLE FORM

TESTS REQUESTED

FBE, CRP, UEC

Test/s Requested

Paediatric samples- list tests in order of priority.

ANTIBIOTIC: .... Spot ☐

Dose: .... mg

Frequency: daily BD Other ....

START administration ..../..../.... .... hour

FINISH administration ..../..../.... .... hour

FIRST SAMPLE/SPOT ..../..../.... .... hour

SECOND SAMPLE ..../..../.... .... hour

Doctor's NAME (print) Citizen Sign .... Date 1/2/14 Pager 123 Phone x43757 Fax ....

Medical Officer's details:
- Name
- Request date
- Contact number

Specimen type/s

SPECIMEN TYPE: X **BLOOD** ☐ **URINE** **OTHER** ....

I certify that I collected the specimen accompanying this request from the stated patient whose details I confirmed by direct inquiry and/or examination of their ID wristband and I labelled the specimen immediately after collection in the presence of the patient.

SIGNED: .... **Print SURNAME:** Molivi

Date: 1 / 2 / 2014 Time: 1306 hour

Your treating practitioner has recommended that you use Monash Pathology. You are free to choose your own pathology provider.

However, if your treating practitioner 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 treating practitioner.

128801 02/17

Collector's declaration
- Signature
- Surname
- Collection date/ time

Red = Mandatory fields Purple = Other fields required, if applicable

Minimum three approved patient identifiers
- UR number/ Full name/ DOB

Clinic/ Ward

Requesting doctor's, full name and provider number or practice location/ address
- JMO use consultant's details

Relevant Clinical details

Test/s Requested

Blood Products required including quantity

MonashPathology

MonashHealth

Monash Health APA 246 Clayton Road Clayton 3168

A/2486

BLOOD BANK REQUEST

PATIENT DETAILS:

UR 999999

Surname TESTING

Given names Fred Lee

Address 246 Clayton Road Clayton, VICTORIA 3168

Ward / Clinic MED

Date of Birth 21/01/1901 Gender M

Medicare number 1 2 3 4 5 6 7 8 9 0 5

Medicare benefits (section 20A Health Insurance Act 1973) By this declaration i assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s)

x Patient's signature 9/14 DATE

Practitioners use only:

reason patient cannot sign

REQUESTING DOCTOR (Name, address and provider number)

Surname & Initials: CITIZEN, J Provider No. 1234567X

Address: 135 David St. Dandenong Victoria. 3175 Pager# 123

Signature: Date 1/ 2 / 14

Extra report to: DOE, J 0123456Y 140 Sladen St Cranbourne

PATIENT STATUS at time of service or specimen collection

	Yes	No
Private patient in a private hospital or approved day hospital facility	☐	☒
A Medicare (public) patient in a recognised hospital	☒	☐
Private patient in a recognised hospital	☐	☒
Outpatient in a recognised hospital	☐	☒

Information required if blood products are requested

CLINICAL NOTES

Diagnosis

Reason for transfusion Low haemoglobin

Haemoglobin

Relevant medical history Post surgery

Blood group (if known) ABO AB Rh D neg

Antibodies Yes/No/UNK

Previous transfusions Yes/No/UNK

Any reactions Yes/No/UNK

Currently pregnant Yes/No/UNK

Previous pregnancies Yes/No/UNK

TESTS REQUESTED

BLOOD COMPONENTS OR PRODUCTS REQUIRED

Date required 02/02/2014 Red Cells 2 units

Time required 0900 Platelets units

Site Clayton FFP units

Other

SPECIAL REQUIREMENTS Yes / No

CMV seronegative

Warmed

Washed

Irradiated

Reason required ....

Special Requirements, if applicable

SPECIMEN COLLECTION (See reverse for labelling requirements)

The person whose signature appears below, and on the sample label, is solely responsible for the correct identification of the patient and the collection and labelling of the blood sample.

I certify that I collected the sample accompanying this request from the stated patient whose details I confirmed by direct inquiry and/or examination of their ID wristband and I labelled the sample immediately after collection in the presence of the patient.

SIGNED Print SURNAME: Molivi

DATE 1 / 2 / 14 TIME 2215 Hour COLLECTION CENTRE MED

Collector's declaration
- Signature
- Surname
- Collection date/ time

FOR LABORATORY USE ONLY — BLOOD GROUP RESULT

BLOOD GROUPING	Antisera A	Antisera B	Antisera Rh(D)	Cells A1	Cells B	ABO	Rh(D)	Signature / Date

COMPATIBILITY/PRODUCT — TRANSFUSION RECORD

Donation Number	Product	Donor blood group	Crossmatch Sal	Crossmatch IAT	Signature	Date	Signature 1	Signature 2	Date / Time
SCI									
SCII									
SCIII									

Antibody Specificity

Special Instructions

Blood Reserved Until 2359

MRL28 02/17

BLOOD BANK REQUEST MRL28

Red = Mandatory fields   Purple = Other fields required, if applicable