

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.

- Fasting
- Non-Fasting
- Pregnant
- Horm Therapy
- LMP
- EDC
- Cervical Cytology**
- Site Cervix
- Vaginal Vault
- Endometrium
- Other
- Post Menopausal
- Post Menopausal
- Radiotherapy
- IUCD
- Abnormal Bleeding
- Appearance of Cervix
- Benign
- Suspicious
- Not for PAP register

Clinical Notes _____

Collection Time

Time/Hours Post Dose

Fasting Non-Fasting Diabetic Thyroxine R Anti-thyroid R Pregnant Self Determined

Urgent Phone Fax By Time: _____

Phone/Fax No: _____

Private Schedule Rebate Bulk Bill

Veteran Affairs: _____

IMPORTANT

Doctor's Signature and Request Date

Global X..... DATE

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 Act 1973)

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.

Practitioner's Use Only:
(Reason patient cannot sign.) _____

Patient's Signature and Date

X..... DATE

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



NAME: _____

D.O.B.: _____

PULL

NAME: _____

D.O.B.: _____

PULL

NAME: _____

D.O.B.: _____

BEND FORM TO REMOVE LABELS

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

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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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X..... DATE



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

