

Patient details	PATIENT LAST NAME	GIVEN NAME (INCLUDING MIDDLE INITIAL)	SEX	DATE OF BIRTH	YOUR REFERENCE
	Barndon	Esther	F	14/06/1983	00418473
PATIENT ADDRESS	POSTCODE			MOBILE PH	ALT PH
124 Craigie Drive Craigie 6025				0433 615 639 (H) 0433 615 639 (M)	0433 065 800

TESTS REQUESTED

Requested tests
BSL; CRP; Ferritin; Iron Studies; TSH; Urine M/C/S; vit D; Vit b12 and folate

fbc, LFT, U+EC

Fasting ☐ Fasting ☐
Non-fasting ☐ Non Fasting ☐
Pregnant ☐ Pregnant ☐
HRT ☐ Horm Therapy ☐
LMP ☐ LNMP ☐
EDC ☐ EDC ☐
CERVICAL CYTOLOGY ☐

Clinical details	Do not send to My Health Record <input type="checkbox"/>
tiredness	<i>fastn</i>
RULE 3 EXEMPTION <input type="checkbox"/>	COLLECTOR'S DECLARATION
SELF DETERMINED <input type="checkbox"/>	SIGNATURE COMPULSORY
REPEAT FORMS <input type="checkbox"/>	I certify that I collected the accompanying sample from the above patient, whose identity was confirmed by inquiry and/or examination of their name-band, and that I labelled the sample immediately following collection.
Urgent <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> By: <input type="checkbox"/>	SIGNED: <i>[Signature]</i> DATE: 08/03/2024
URGENT <input type="checkbox"/> Phone/Fax No.: <input type="checkbox"/>	DOCTOR'S SIGNATURE AND REQUEST DATE
PHONE/FAX No.: <input type="checkbox"/>	<i>[Signature]</i> 08/03/2024
Private <input type="checkbox"/> Concession <input type="checkbox"/> Direct Bill <input checked="" type="checkbox"/>	DOCTOR
PRIVATE <input type="checkbox"/> SCHEDULE FEE <input type="checkbox"/> BULK BILL <input type="checkbox"/>	DATE: <input type="checkbox"/>
DVA/WC No.: <input type="checkbox"/>	
VET AFFAIRS No.: <input type="checkbox"/>	

Copies to:	Requesting practitioner
	Dr Depak Naran
	14 Burragah Way
	Duncraig 6023
	Ph: 92469922
	2509595J
HOSPITAL/WARD:	

MEDICARE ASSIGNMENT (Section 20A of the Health Insurance Act 1973) 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. In the alternate I authorise Australian Clinical Labs to submit my unpaid account to Department of Human Services so that Department of Human Services can assess my claim and issue a cheque to me payable to Australian Clinical Labs for the Medicare benefit. I acknowledge and accept that I may receive an out of pocket invoice for these tests and I will be responsible for payment of this invoice.	PENSIONER/HCC HOLDER - PATIENT'S SIGNATURE AND DATE	FOR HOSPITAL PATIENTS
Practitioner's Use Only Reason patient cannot sign:	PATIENT DATE: / /	Patient status at the time of the service or when the specimen was collected:
	See over for Billing Policy and Privacy Note	1. Private patient in a private hospital or approved day hospital facility <input type="checkbox"/> yes <input type="checkbox"/> no
		2. Private patient in a recognised hospital <input type="checkbox"/> yes <input type="checkbox"/> no
		3. A public patient in a recognised hospital <input type="checkbox"/> yes <input type="checkbox"/> no
		4. Outpatient of a recognised hospital <input type="checkbox"/> yes <input type="checkbox"/> no

TUBES	URINE	SLIDES	CONTAINERS	SWABS:	OTHER:
EDTA ESR FL OX GEL HEP PLAIN SOD CIT 24 HR CHEM CYTO MSU PCR CYTO MICRO PAP CSF FAECES FUNG HIST SPUT					

AUSTRALIAN
Clinicallabs Perth
Pathology

PATHOLOGY REQUEST FORM
All Enquiries 1300 134 111
clinallabs.com.au

PATIENT COPY

MEDICARE CARD NUMBER

TITLE	PATIENT LAST NAME	GIVEN NAME (INCLUDING MIDDLE INITIAL)	SEX	DATE OF BIRTH	YOUR REFERENCE
PATIENT ADDRESS					
POSTCODE					
MOBILE PH					
ALT PH					
TESTS REQUESTED					
REQUESTING DOCTOR (PROVIDER NUMBER, SURNAME & INITIALS, ADDRESS)					
PATIENT COPY					
IMPORTANT NOTE: Your doctor has recommended that you use Australian Clinical Labs. 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.					
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 or to a person in the medical practice associated with this claim, or as authorised/required by law.					

23 Walters Drive, Oscome Park 6017 Clinical Labs (WA) P/L APA 1183 ABN 98 612 976 691