



# SURGICAL SKIN AUDIT PATHOLOGY REQUEST

Ph (02) 9005 7111 Fax (02) 9005 7116 www.kossard.com.au

MEDICARE CARD NUMBER

BARCODE

Specialist Diagnostic Services Pty Ltd ABN 84 007 190 043 APA No 000042 trading as Laverty Pathology and Kossard Dermatopathologists

## LAB NUMBER & IMAGE/FAX BOTH SIDES OF FORM

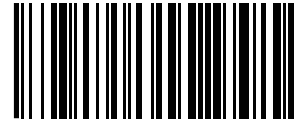
|                   |  |             |          |                     |           |
|-------------------|--|-------------|----------|---------------------|-----------|
| PATIENT LAST NAME |  | GIVEN NAMES | SEX      | DATE OF BIRTH       | FILE No.  |
| PATIENT ADDRESS   |  |             | POSTCODE | TEL (HOME & MOBILE) | TEL (BUS) |

TESTS REQUESTED

Completing both sides of this form is essential for audit inclusion

LABORATORY COPY  
LAB NO. & IMAGE/FAX BOTH SIDES OF FORM

CLINICAL NOTES



Do not send reports to My Health Record

- SELF DETERMINE  
 STANDARD PRECAUTIONS  PRIVATE & CONFIDENTIAL

STANDARD FEE

CONCESSIONAL FEE

URGENT  PHONE  FAX  BY TIME:

PHONE/FAX No:

VETERANS' AFFAIRS No:

DOCTOR'S SIGNATURE AND REQUEST DATE

COPY REPORTS TO:

REQUESTING DOCTOR (PROVIDER NUMBER, SURNAME, INITIALS, ADDRESS)

|           |  |  |  |  |
|-----------|--|--|--|--|
| Doct      |  |  |  |  |
| Copy 1    |  |  |  |  |
| Copy 2    |  |  |  |  |
| Copy 3    |  |  |  |  |
| Hosp/Ward |  |  |  |  |

HOSPITAL/WARD

|               |            |                                                                |        |          |          |                          |           |
|---------------|------------|----------------------------------------------------------------|--------|----------|----------|--------------------------|-----------|
| Collect Date  | Coll. Time | Test Codes                                                     | Branch | Ref. No. | Lab. No. | Description & Containers | Collector |
| Received Date | Rec. Time  | Attachments: Yes / No (please circle)<br>If yes, no. of pages: | B/C    | Clinic   |          |                          |           |

Was or will the patient be, at the time of the service or when the specimen is obtained: (✓ appropriate box)

|                                                                              |                          |                          |
|------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. a private patient in a private hospital or approved day hospital facility | yes                      | no                       |
| 2. a private patient in a recognised hospital                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. a public patient in a recognised hospital                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. an outpatient of a recognised hospital                                    | <input type="checkbox"/> | <input type="checkbox"/> |

### PATIENT'S SIGNATURE AND DATE

**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 that APP to submit my unpaid account to Medicare so that Medicare can assess my claim and issue me a cheque payable to the APP for the Medicare Benefit.

SIGNATURE X ..... X DATE / /

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

|         |         |         |
|---------|---------|---------|
| NAME:   | NAME:   | NAME:   |
| D.O.B.: | D.O.B.: | D.O.B.: |



MEDICARE CARD NUMBER

|                   |  |             |          |                     |           |
|-------------------|--|-------------|----------|---------------------|-----------|
| PATIENT LAST NAME |  | GIVEN NAMES | SEX      | DATE OF BIRTH       | FILE No.  |
| PATIENT ADDRESS   |  |             | POSTCODE | TEL (HOME & MOBILE) | TEL (BUS) |

TESTS REQUESTED

PATIENT COPY

LAB NO. & IMAGE/FAX BOTH SIDES OF FORM

Your treating practitioner has recommended that you use Kossard Dermatopathologists and Laverty 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.

REQUESTING DOCTOR (PROVIDER NUMBER, SURNAME, INITIALS, ADDRESS)

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# Surgical Audit Data Collection

Doctor please: Record details below.

Label and number each specimen clearly.

Office use only

Place lab number barcode here

| Specimen Region<br>(See key below) | Specimen Location<br>(Unless provided other side) | Provisional Diagnosis<br>(See key) | Dermoscopy used?<br>Yes/No | Past Biopsy Result<br>(See key) | Disease Category<br>(See key) | Current Biopsy Type<br>(See key) | Current Surgical Management<br>(See key) | Sequentially Monitored Lesion<br>Yes/No | IF RELEVANT:<br>Rapid Access Dermatology Clinic<br>Yes/No |
|------------------------------------|---------------------------------------------------|------------------------------------|----------------------------|---------------------------------|-------------------------------|----------------------------------|------------------------------------------|-----------------------------------------|-----------------------------------------------------------|
| 1                                  |                                                   |                                    |                            |                                 |                               |                                  |                                          |                                         |                                                           |
| 2                                  |                                                   |                                    |                            |                                 |                               |                                  |                                          |                                         |                                                           |
| 3                                  |                                                   |                                    |                            |                                 |                               |                                  |                                          |                                         |                                                           |
| 4                                  |                                                   |                                    |                            |                                 |                               |                                  |                                          |                                         |                                                           |
| 5                                  |                                                   |                                    |                            |                                 |                               |                                  |                                          |                                         |                                                           |
| 6                                  |                                                   |                                    |                            |                                 |                               |                                  |                                          |                                         |                                                           |
| 7                                  |                                                   |                                    |                            |                                 |                               |                                  |                                          |                                         |                                                           |
| 8                                  |                                                   |                                    |                            |                                 |                               |                                  |                                          |                                         |                                                           |

## Key

### Specimen Region

- Nose
- Lip
- Ear
- Eyelid
- Other Face
- Scalp
- Neck
- Shoulder
- Chest
- Abdomen
- Back
- Buttock
- Genitalia
- Arm
- Forearm (Elbow and below)
- Hand
- Finger
- Thigh
- Leg (Knee and below)
- Foot
- Toe
- Palm or Sole

### Provisional Diagnosis or Past Biopsy Result

|        |                              |
|--------|------------------------------|
| BCC    | Basal Cell Carcinoma         |
| IEC    | IEC/Bowens Disease           |
| SCC    | Squamous Cell Carcinoma      |
| MMis   | Melanoma: in situ / HMF      |
| MMinv  | Melanoma: invasive           |
| MMmet  | Melanoma: metastasis         |
| OM     | Other Malignant              |
| N      | Naevus: Benign               |
| DN     | Naevus: Dysplastic           |
| BN     | Naevus: Blue                 |
| SN     | Naevus: Spitz                |
| SK     | Solar Keratosis              |
| KA     | Keratoacanthoma              |
| SL     | Solar Lentigo                |
| SebK   | Seborrhoeic Keratosis        |
| LPLK   | Lichen Planus Like Keratosis |
| DF     | Dermatofibroma               |
| SGH    | Sebaceous Gland Hyperplasia  |
| B Cyst | Benign Cyst                  |
| OB     | Other: Benign                |

### Disease Category

|      |                 |
|------|-----------------|
| Mel  | Melanocytic     |
| NMSC | Non Melanocytic |
|      | Skin Cancer     |
| Inf  | Inflammatory    |
| O    | Other           |

### Current Biopsy Type

|    |                |
|----|----------------|
| P  | Punch          |
| PE | Punch Excision |
| S  | Shave          |
| SE | Shave Excision |
| I  | Incisional     |
| E  | Excisional     |
| C  | Curettage      |
| O  | Other          |

### Current Surgical Management

|      |                       |
|------|-----------------------|
| E    | Ellipse               |
| F    | Flap                  |
| Ssg  | Graft: SSG            |
| FTG  | Graft: FTG            |
| NC   | No Closure            |
| SxEx | Shave/Saucerisation   |
| CxCx | Curettage and Cautery |
| O    | Other                 |