

PATIENT LAST NAME / ADDRESS	GIVEN NAMES	SEX	DATE OF BIRTH	YOUR REF:	
		TEL (HOME)	TEL (BUS)		

TESTS REQUESTED	Fasting <input type="checkbox"/> Non Fasting <input type="checkbox"/> Pregnant <input type="checkbox"/> Horm Therapy <input type="checkbox"/> LNMP <input type="checkbox"/> EDC <input type="checkbox"/> <b>CERVICAL CYTOLOGY</b> SITE Cervix <input type="checkbox"/> Vaginal Vault <input type="checkbox"/> Endometrium <input type="checkbox"/> Other <input type="checkbox"/> Post Natal <input type="checkbox"/> Post Menopausal <input type="checkbox"/> Radio Therapy <input type="checkbox"/> IUUC <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> APPEARANCE Benign <input type="checkbox"/> OF CERVIX <input type="checkbox"/> Suspicious <input type="checkbox"/>
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Learn about your tests:  
[knowpathology.com.au](http://knowpathology.com.au)

CLINICAL NOTES	SELF DETERMINED <input type="checkbox"/>	<b>CERVICAL SCREENING TEST:</b> <input type="checkbox"/> Practitioner Collect <input type="checkbox"/> Self-Collect LBC AND HPV TESTS NOT MEETING CRITERIA ARE <b>NOT</b> COVERED BY MEDICARE.
Fasting <input type="checkbox"/> Non-fasting <input type="checkbox"/> Diabetic <input type="checkbox"/> Thyroxine R <input type="checkbox"/> Antithyroid R <input type="checkbox"/>		Collection Time [ ] : [ ] Hours p.c. [ ] : [ ] Hours post dose [ ] : [ ]  <b>DOCTOR'S SIGNATURE AND REQUEST DATE</b> _____ DATE ...../...../.....
Urgent <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> By Time: _____ Private <input type="checkbox"/> Schedule <input type="checkbox"/> Medicare <input type="checkbox"/> Vet Affairs: _____		

COPY REPORTS TO:	ACC STAMP
HOSPITAL/WARD	
Collector Declaration: I certify that I collected the accompanying sample from the above patient whose identity was confirmed by enquiry and that I labelled the sample immediately following collection. Collector's Signature X _____	REQUESTING PRACTITIONER (Provider No., Surname, Init., Address)

Patient status at the time of the service or when the specimen was collected 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	yes no <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	I refer to assign my right to benefits to the approved pathology practitioner ("APP") who will render the requested pathology services and any eligible pathologist determinable service(s) established as necessary by the practitioner. Alternatively, I authorise APP to submit my unpaid account to Medicare so that Medicare can assess my claim and issue a cheque to me, payable to the APP for the Medicare Benefit.
PATIENT SIGNATURE X _____		DATE ...../...../.....

LAB USE	Collected By						Collect Date						TUBES						URINES			SWABS							
	EDTA		CIT		SST		Plain		Fluoride		HEP		Other		Spot			24 Hr			MICRO			VIRAL			Other		
	CONTAINERS		HISTO		SLIDES			OTHER			SRA USE																		
PT	Claim Form	Pyr	AC	COLL SUBM	DV REF PAT	Faeces	Semen	LBC	Other	PAP	MICRO	Other	Describe	Sign	Date	Time													

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TESTS REQUESTED	CLEAR FORM <input type="button" value="CLEAR FORM"/> SAVE <input type="button" value="SAVE"/>
PATIENT COPY	
REQUESTING PRACTITIONER (Provider No., Surname, Initials, Address)	

**CERVICAL SCREENING TEST:**  Practitioner Collect  Self-Collect  
 LBC AND HPV TESTS NOT MEETING CRITERIA ARE **NOT** COVERED BY MEDICARE.

Your treating practitioner has recommended that you use Lavery 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.

**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.