CAPITAL PATHOLOGY
Quality is in our DNA

Doctors Service Centre: 02 6285 9803

Laboratory address: Equinox 4, Ground Floor,
70 Kent St, DEAKIN, ACT 2600, Ph: 02 6285 9800 Fax: 02 6285 9941
APA Capital Pathology Pty Ltd ACN 069 467 447 as trustee of the Capital Pathology Trust ABN 49 452 500 422

IRN/MEDICARE CARD NUMBER

Instrument Number A/4305

www.capitalpath.com.au

PATIENT LAST NAME | GIVEN NAME (INCLUDING MIDDLE INITIAL) | SEX | DATE OF BIRTH / / | YOUR REFERENCE

PATIENT ADDRESS | POSTCODE | TEL (HOME) | TEL (BUS)

TESTS REQUESTED

When complete, click the Submit button to save the form and email it to the Doctors Services Centre

LABORATORY COPY

CLINICAL NOTES

Collection Room

SD ☐

URGENT ☐ PHONE ☐ FAX ☐ BY TIME:
PHONE/FAX No.:
STANDARD ☐ SCHEDULE ☐ DIRECT BILL ☐
VETAFFAIRS/OTHER No.:

DOCTOR'S SIGNATURE AND REQUEST DATE

/ /

- Fasting ☐
- Non Fasting ☐
- Pregnant ☐
- Horm. Therapy ☐
- LNMP ☐
- EDC ☐

CERVICAL SCREENING:

SITE:
- Cervix ☐
- Vagina ☐
- Self-collect ☐

CLINICAL:
- Pregnant ☐
- Postnatal ☐
- Post-menopausal ☐
- Hysterectomy ☐
- HRT/OCP ☐
- IUD ☐

SYMPTOMS:
- Post-menopausal bleeding ☐
- Post-coital bleeding x 1 ☐
- Post-coital bleeding recurrent ☐
- Unexplained bleeding ☐
- Suspicious cervix ☐

OTHER:
- <25yr old meeting specific criteria ☐
- Immune-deficient ☐
- DES exposed ☐
- Previous AIS ☐

COPY REPORTS TO:

HOSPITAL / WARD

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

Was or will the patient be, at the time of the service or when the specimen is obtained a:	yes	no
A private patient in a private hospital or approved day hospital facility?	☐	☐
Private patient in a recognised hospital?	☐	☐
A public patient in a recognised hospital?	☐	☐
An out-patient of a recognised hospital?	☐	☐

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.

Practitioner's Use Only (Reason for Patient being unable to sign)

Patient Signature Date / /

NOTE: PERSON COLLECTING SPECIMEN

I certify that I collected the accompanying sample from the above patient whose identity was confirmed by enquiry and/or examination of their name band and that I labelled the sample immediately following collection.

Date: / / Time:
Signed:

Collection Code | Location Code

GEL	CLOT	EDTA	GLUC	CIT	HEP	Urine	Faeces	Bod FL	Sputum	CSF	Histo	PAP	Swab	ECG	TX Form	Other	Initials

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Submit

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TESTS REQUESTED

National Cancer Screening Register (NCSR)
The National Cancer Screening Register (NCSR) is an 'opt out' register. Pathology laboratories can no longer act on 'not for register' instructions on the pathology request form. Patients who wish to alter their consent status must contact the register directly on 1800 627 701.

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Patient Signature Date / /

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