PATHOLOGY REQUEST FORM

Australian Rickettsial Reference Laboratory Foundation Ltd

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ABN: 14103665621 web: www.rickettsialab.org.au
A WHO Collaborative Centre
for Reference and Research on Rickettsioses

Title	Patient Surname	Given Name	Sex	Date of Birth	Medicare Number

Address		Postcode	Mobile Number	Your Reference

TESTS REQUESTED

CLINICAL NOTES

SPECIMEN TYPE	PERSON COLLECTIONG SPECIMEN TO COMPLETE

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I certify that I have collected the accompanying sample from the above patient whose identity has been confirmed by inquiry and I labelled the sample immediately following collection.

Signed: Full Name:

Date: Time:

DOCTOR'S SIGNATURE

DATE:

REQUESTING DOCTOR
(Provider number, Surname and initial, Address)

COPY REPORTS TO

MEDICARE ASSIGNMENT (Section 20A of the Health Insurance Act 1973), I assign my rights to benefits to the approved pathology practitioner who will render the requested pathology service(s).

PATIENT SIGNATURE

DATE:

PATiENT BILLING POLICY: The Australian Rickettsial Reference Laboratory reserves the right to privately bill test listed and/or unlisted in the Medicare Benefits Schedule.

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 records. Its collection is authorised by provisions of the Health Insurance Act 1973. This information may be disclosed to the Health Department or to a person in the medical practice associated with this claim, or as authorised or required by law.

FOR HOSPITAL PATIENTS

Tick applicable

Private patient in a private hospital ☐
Private patient in a recognised hospital ☐
Public patient in a recognised hospital ☐
Outpatient of a recognised hospital ☐

OTHER BILLING CATEGORIES

Private ☐
Pensioner ☐
Veterans Affairs ☐
WorkSafe / TAC ☐
Other _____ ☐