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| **Medicare Card Number - IRN** | **Expiry** |
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**Pathology Request** (Egg provider) **– Laboratory Copy**

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| **Patient Surname:** | **Patient Given Name/s:** | **Sex:** | **Date of Birth** | **GP reference number:** |
|  |  |  |  |  |
| **Patient Address:** | **Patient Phone:** |
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| **Tests Requested** | **Containers Collected** |
| Hep B & C, HIV, Syphilis, Rubella, Varicella, FBE, Ferritin, Blood group & antibodies, FSH, LH, Estradiol (E2), Prolactin, Ferritin, TSH, free testosterone, Sex Hormone Binding Globulin (SHBG) |  |
| **Clinical Notes** (including relevant medications) | **Self Determined** [ ]  | **Rule 3 Exemption** [ ]  |
| Infertility. PFC referralEgg provider |
| [ ]  **URGENT****By Date & Time:** |  | **Phone**: [ ] **Number:** |  | **Fax:** [ ] **Number:** |  | **Requesting Doctor’s signature and request date:**Circle with right arrow **Date: / /** |
| **Private** [ ]  |  | **Concession** [ ]  |  | **Bulk Bill** [x]  |  | **Vet affairs/work comp number:**  |
| **Copy Reports to:** Public Fertility Care, Royal Women’s Hospital20 Flemington Road, Parkville**Hospital/Ward:**  | **Requesting Doctor** Name:Provider no.:Address:Phone: |
| **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 services and any eligible pathologist determinable services established as necessary by the practitioner. **PATIENT ACCOUNT STATEMENT:** Your doctor has requested tests for clinical reasons. Some of these may not be eligible for a Medicare rebate, and you may incur an out of pocket expense. For full details refer to your pathology provider.**Patient signature: Reason cannot sign: Date: / /** Circle with right arrow |
| **Specimen Collected****Date****Time** | I certify that I collected the specimen accompanying this request form the stated patient whose details I confirmed by direct enquiry and/or examination of their ID wristband and I labelled the specimen immediately after collection in the presence of the patient.**Collector Surname (print): Collector Signature:** Circle with right arrow |

 **Pathology Request Form** (Egg provider) **- Patient Copy**

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| **Medicare Card Number - IRN** | **Expiry** |
|  |  |

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| --- | --- | --- | --- | --- |
| **Patient Surname:** | **Patient Given Name/s:** | **Sex:** | **Date of Birth** | **GP reference number:** |
|  |  |  |  |  |
| **Patient Address:** | **Medicare number – IRN (expiry)** | **Patient Phone:** |
|  |  |  |
|  |  |  |  |  |
| **Tests Requested** | **Requesting Doctor** (surname & initials, address, phone & provider no.) |
| Hep B & C, HIV, Syphilis, Rubella, Varicella, FBE, Ferritin, Blood group & antibodies, FSH, LH, Estradiol (E2), Prolactin, Ferritin, TSH, free testosterone, Sex Hormone Binding Globulin (SHBG) |  |
| **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 services and any eligible pathologist determinable services established as necessary by the practitioner. **PATIENT ACCOUNT STATEMENT:** Your doctor has requested tests for clinical reasons. Some of these may not be eligible for a Medicare rebate, and you may incur an out of pocket expense. For full details refer to your pathology provider.**Patient signature: Reason cannot sign: Date: / /** Circle with right arrow |