VCGS General Request Form

Victorian Clinical Genetics Services
Murdoch Childrens Research Institute
The Royal Children's Hospital
Flemington Road, Parkville VIC 3052
P +61 1300 118 247 **F** +61 3 8341 6366
W vcgs.org.au

PATIENT DETAILS

LAST NAME | GIVEN NAMES | SEX | DATE OF BIRTH | LABORATORY REF / UR / MRN

ADDRESS | POST CODE | PHONE (home) | MOBILE

TESTS REQUESTED

SAMPLE TYPE: Li-Hep ☐ EDTA ☐ Saliva ☐
Other:

MEDICARE ASSIGNMENT
Medical Assignment: (Section 20A of the Health Insurance Act 1973). I offer to assign my right 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.

MEDICARE NUMBER: _____

SIGNATURE: _____DATE: _____

Your doctor has recommended you use Victorian Clinical Genetics Services (VCGS). You are free to choose your own pathology provider. However, if your doctor has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performed the service. You should discuss this with your doctor.

CLINICAL NOTES

SPECIMEN COLLECTION SIGNATURE
Time of collection:
SIGNATURE: Date of collection:

DOCTOR'S SIGNATURE AND REQUEST DATE
DATE:
SIGNATURE:

COPY REPORTS TO:

REQUESTING DOCTOR (provider #, initials, address):

HOSPITAL STATUS OF PATIENT AT SPECIMEN COLLECTION OR DATE OF SERVICES

YES	NO		YES	NO	
☐	☐	Private patient in a private hospital or approved day hospital facility	☐	☐	Hospital patient in a recognised hospital
☐	☐	Private patient in a recognised hospital	☐	☐	Outpatient of a recognised hospital

SEND SAMPLES TO:

Victorian Clinical Genetics Services
4th Floor, Murdoch Children's Research Institute
The Royal Children's Hospital
50 Flemington Road, Parkville VIC 3052
P 03 1300 118 247 W vcgs.org.au E vcgs@vcgs.org.au

Payment agreement / authorisation

for privately funded tests - complete if applicable

- ○ HEALTH / OTHER SERVICE
- ○ PATIENT / GUARDIAN
- ○ VCGS

I/we agree to pay for the above testing

NAME: _____ COST: _____

SIGNED: _____ DATE: _____

ADDRESS: _____

_____ POSTCODE: _____

EMAIL: _____ PHONE / MOBILE: _____