

Laboratory No. \_\_\_\_\_

**PATIENT DETAILS**

UR: \_\_\_\_\_ GF: \_\_\_\_\_

SURNAME \_\_\_\_\_ GIVEN NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

POSTCODE \_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ SEX \_\_\_\_\_ TELEPHONE \_\_\_\_\_

CLINIC VCGS RWH Other \_\_\_\_\_

**MEDICARE NUMBER** \_\_\_\_\_

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.

Patient sig: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_

**CLINICAL NOTES (inc. medications)**

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.

**REQUESTING PRACTITIONER (please print)**

SURNAME \_\_\_\_\_ INITIALS \_\_\_\_\_

ADDRESS \_\_\_\_\_

POSTCODE \_\_\_\_\_

PROVIDER NO. \_\_\_\_\_

COPY TO (Dr Name & address)

**CONTACT DETAILS FOR URGENT RESULTS**

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**TESTS REQUESTED**

DOCTOR'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**SPECIMEN COLLECTION**

I certify that the accompanying specimen was collected from the patient stated above as ascertained by inquiry and/or examination of name band.

COLLECTORS SIGNATURE: \_\_\_\_\_ Collection date \_\_\_/\_\_\_/\_\_\_ Collection time \_\_\_\_\_