A/4401

SOUTHERNSUN Pathology

Southern Sun Pathology Pty Ltd APA ACN 131 558 971
Suite 16, 7 Sefton Road, Thornleigh NSW 2120
Ph: 02 9473 5200 Fax: 02 9473 5299 www.southernsunpathology.com.au

MEDICARE/VETERANS CARD NUMBER

MEDICARE REF NUMBER
EXPIRY DATE

PATHOLOGY REQUEST

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

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

TESTS REQUESTED

Specimen A	Specimen B	Specimen C
Site:	Site:	Site:
Specimen Type:	Specimen Type:	Specimen Type:
Clinical dx:	Clinical dx:	Clinical dx:
Margins y/n:	Margins y/n:	Margins y/n:
Previous specimen y/n:	Previous specimen y/n:	Previous specimen y/n:

Note: Specimen Types: Punch, shave, curette, excision – write if punch excision

☐ SD Self Determine (APP requirement only)

EMERGENCY ☐ PHONE ☐ FAX ☐ BY TIME

PHONE/FAX No.:

PRIVATE ☐ SCHEDULE ☐ MEDICARE ☐ SD ☐

DOCTOR'S SIGNATURE AND REQUEST DATE

X...../...../.....

COPY REPORTS TO:

HOSPITAL / WARD

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

Hospital status of patient at specimen collection or date of service

	Yes	No
Private patient in a private hospital or approved day hospital facility.	☐	☐
Private patient in a recognised hospital	☐	☐
A public patient in a recognised hospital	☐	☐
Outpatient of a recognised hospital	☐	☐

PATIENT'S SIGNATURE AND DATE 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. Patient Signature..... Date...../...../.....

PRACTITIONER'S USE ONLY

..... (Reason patient cannot sign)

1. Please ensure both patient name and date of birth are complete prior to removing label.
2. Remove label and attach to specimens.
3. If more than three specimens, please record patient details directly on additional containers.

NAME: D.O.B.: PULL	NAME: D.O.B.: PULL	NAME: D.O.B.: PULL

PLEASE DO NOT USE LABELS ON GLASS SLIDES – BEND FORM TO REMOVE LABELS

SOUTHERNSUN Pathology
Southern Sun Pathology Pty Ltd APA ACN 131 558 971
Suite 16, 7 Sefton Road, Thornleigh NSW 2120
Ph: 02 9473 5200 Fax: 02 9473 5299 www.southernsunpathology.com.au

MEDICARE/VETERANS CARD NUMBER

MEDICARE REF NUMBER
EXPIRY DATE

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

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

TESTS REQUESTED

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

PATIENT COPY

Hospital status of patient at specimen collection or date of service

	Yes	No
Private patient in a private hospital or approved day hospital facility.	☐	☐
Private patient in a recognised hospital	☐	☐
A public patient in a recognised hospital	☐	☐
Outpatient 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. Patient Signature..... Date...../...../.....

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