

Updated Austin Pathology Request Forms

Services Australia has recently introduced new data requirements for all bulk billing requests.

As a result, updates have been made to the Austin Pathology request forms.

Please take note of the following changes when completing the forms:

1. The 'Patient's Signature and Date' field and the 'Collector's Signature' field have swapped positions.

2. Additional tick boxes have been added to the 'Patient's Signature and Date' section.

The patient must now indicate Yes or No to the Question: Is the patient the assignor?

Please ensure that all relevant fields continue to be completed.

More information is available in the Department of Health's '[Assignment of Medicare Benefits for Bulk Billing-FAQ](#)' document.

If have any questions, please contact Client Services at pathclientservices@austin.org.au or 03 9496 5219.

Austin HEALTH Pathology		MEDICARE CARD NO.	PRE-ASSIGNMENT PATHOLOGY REQUEST  		Austin Health APA 145 Studley Rd Heidelberg VIC 3084 www.austinpathology.org.au 9496 3100																																																																	
PATIENT SURNAME _____ GIVEN NAME(S) _____ MRN _____ PATIENT ADDRESS _____ POSTCODE _____ DATE OF BIRTH / / SEX TELEPHONE _____			REFERRING DOCTOR (NAME, PROVIDER NUMBER, ADDRESS) _____ DOCTOR CODE _____																																																																			
HC FACILITY _____ WARD _____ COLL. CENTRE _____ Public ☐ MBS ☐			COPY TO: (NAME, PROV NO., ADDRESS) _____ COPY TO: (NAME, PROV NO., ADDRESS) _____																																																																			
CLINICAL NOTES FASTING Yes ☐ No ☐ PREGNANT Yes ☐ Weeks _____ MEDICATION / TLD _____			TESTS REQUESTED URGENT ☐ PHONE _____ FAX _____ DOCTOR'S SIGNATURE AND REQUEST DATE _____ Practitioner's Use Only (Reason for patient being unable to sign) _____																																																																			
☐ SD ☐ Do Not Send Report to My Health Record			I certify that I collected the accompanying specimen from the above patient whose identity was confirmed by enquiry and/or examination of their ID wristband, and that I labelled the specimen immediately following collection before leaving the patient. SIGNED: _____ NAME (Print): _____																																																																			
Hospital status of patient at specimen collection or date of service Private patient in a private hospital or approved day hospital facility Yes ☐ No ☐ Private patient in a recognised hospital Yes ☐ No ☐ Public patient in a recognised hospital Yes ☐ No ☐ Outpatient of a recognised hospital Yes ☐ No ☐			LOCATION INITIALS C V A I S D DATE TIME																																																																			
PATIENT'S SIGNATURE AND DATE Is the patient the assignor: ☐ Yes ☐ No By this declaration I assign my right to benefits to the Approved Pathology Practitioner who will render the requested pathology service(s) and any pathology-determinable service. _____																																																																						
<table border="1"> <thead> <tr> <th colspan="5">TUBES</th> <th colspan="5">URINE</th> <th colspan="3">SWABS</th> <th colspan="2">SLIDES</th> <th colspan="2">CONTAINERS</th> <th colspan="2">OTHER</th> </tr> <tr> <th>GEL</th> <th>PLAIN</th> <th>EDTA</th> <th>EDTA 9 mL</th> <th>FLOX</th> <th>CITRATE</th> <th>HEPARIN</th> <th>RACE</th> <th>BACTO</th> <th>CYTO</th> <th>24HR</th> <th>PCR</th> <th>ORANGE</th> <th>WHITE</th> <th>GREEN</th> <th>RED</th> <th>PINK</th> <th>BACTO</th> <th>CYTO</th> <th>ACCES</th> <th>SEMEN</th> <th>HISTO</th> <th>DESCRIBE</th> </tr> </thead> <tbody> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table>						TUBES					URINE					SWABS			SLIDES		CONTAINERS		OTHER		GEL	PLAIN	EDTA	EDTA 9 mL	FLOX	CITRATE	HEPARIN	RACE	BACTO	CYTO	24HR	PCR	ORANGE	WHITE	GREEN	RED	PINK	BACTO	CYTO	ACCES	SEMEN	HISTO	DESCRIBE																							
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PATIENT'S SIGNATURE AND DATE Is the patient the assignor: ☐ Yes ☐ No By this declaration I assign my right to benefits to the Approved Pathology
