



DR ANDREW CLOUSTON
DR CATHERINE CAMPBELL
DR NEAL WALKER
DR IAN BROWN
DR CHRISTOPHE ROSTY

DR MARK BETTINGTON
DR GREGORY MILLER
Unit 5, 38 Bishop Street,
Kelvin Grove QLD 4059
P 07 3552 6400 F 07 3352 4266

MEDICARE CARD NUMBER

Clouston Pathology Pty Ltd ABN 33 122 927 128 | APA No. 1078

A/3640

REQUEST FORM

PATIENT LAST NAME	GIVEN NAMES	SEX	DATE OF BIRTH	YOUR REFERENCE
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PATIENT ADDRESS	TEL(HOME)	TEL(BUS)
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TESTS REQUESTED	<p>Patient status at time of the service or specimen collection</p> <table border="1"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>(1) a private patient in a private hospital or approved day hospital facility</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>(2) a private patient in a recognised hospital, or</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>(3) a public patient in a recognised hospital, or</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>(4) an outpatient in a recognised hospital</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table> <p><input type="checkbox"/> Pre Admission <input type="checkbox"/> Referred Outpatient <input type="checkbox"/> Post Discharge</p>		Yes	No	(1) a private patient in a private hospital or approved day hospital facility	<input type="checkbox"/>	<input type="checkbox"/>	(2) a private patient in a recognised hospital, or	<input type="checkbox"/>	<input type="checkbox"/>	(3) a public patient in a recognised hospital, or	<input type="checkbox"/>	<input type="checkbox"/>	(4) an outpatient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>
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(3) a public patient in a recognised hospital, or	<input type="checkbox"/>	<input type="checkbox"/>														
(4) an outpatient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>														

CLINICAL NOTES
<input type="checkbox"/> SELF DETERMINE

URGENT <input type="checkbox"/> PHONE <input type="checkbox"/> FAX <input type="checkbox"/> BY TIME: _____ PHONE/FAX No: _____ Private <input type="checkbox"/> Schedule Fee <input type="checkbox"/> Bulk Bill <input type="checkbox"/> Veteran Affairs No. _____	REQUESTING DOCTOR'S SIGNATURE AND REQUEST DATE X _____ DOCTOR'S SIGNATURE _____ DATE _____
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COPY REPORTS TO:	REQUESTING DOCTOR (PROVIDER NUMBER, NAME, INITIALS, ADDRESS)
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LABORATORY COPY

Your doctor has recommended that you use Envoi Specialist Pathologists. 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 performs the service. You should discuss this with your doctor

Clinicians check box if Envoi only is requested on clinical grounds.

MEDICARE

MEDICARE ASSIGNMENT

(Section 20A of the Health Insurance Act 1973)

I assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s).

PATIENT'S SIGNATURE AND DATE: _____ / ____ / ____

X _____

PRACTITIONER'S USE ONLY
(Reason patient cannot sign)



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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 the person in the medical practice associated with this claim, or as authorised/required by law.

PATIENT COPY