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Patient last name	Given name(s)	Sex	Date of birth	Your reference
Patient address	Post code	Telephone home	Telephone work	

Tests requested

**Fasting**   
**Non fasting**   
**Pregnant**

Hormone Therapy   
 LMP   
 ECD

Clinical notes

Self determine

LAB USE	Initial	Date
Tubes 1 2 3 4 5 6 7 8 9		
EDTA Plain Gel Citrate Fluoride Other		
Other 1 2 3 4 5 6 7		
Urine 24h Urine Pap Smear Histo Semen		
Bac Slide Film Swab Faeces Sputum		

**Cervical cytology site**

Cervix   
 Vaginal vault   
 Endometrium   
 Other

Post natal   
 Radio therapy   
 Post menopausal   
 IUD   
 Abnormal bleeding

**Appearance of cervix**

Benign   
 Suspicious

<p><b>Urgent</b> <input type="checkbox"/> <b>Phone</b> <input type="checkbox"/> <b>SMS (INR)</b> <input type="checkbox"/> <b>Fax</b> <input type="checkbox"/> <b>By time</b> <input type="checkbox"/></p> <p>Phone/fax no. <input type="checkbox"/></p> <p>Private <input type="checkbox"/> Rebate <input type="checkbox"/> <input checked="" type="checkbox"/> <b>Bulk bill</b></p> <p>Vet affairs <input type="checkbox"/></p>	<p>Doctors signature</p> <p>X</p> <p>Date: / /</p>
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Copy reports to	Requesting doctor (surname and initials, address, provider number)	<p>I certify that I collected the accompanying sample from the above patient whose identity was confirmed by enquiry and/or examination of their name band and that I labelled the sample immediately following collection.</p> <p>Collected by</p> <p>Time</p>
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Reason patient cannot sign (Practitioner use only)

**Medicare Assignment (Section 20A of the Health Insurance Act 1973)**  
**TO BE COMPLETED BY THE PERSON ASSIGNING BENEFITS FOR THE SERVICES ON THIS FORM**  
 I assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s).

Patient signature X Date: / /

Patient status at time of the service or when specimen was collected:

(a) A private patient in a private hospital or approved day hospital facility	Yes <input type="checkbox"/>	No <input type="checkbox"/>	↑ L I F T	NAME:	↑ L I F T	NAME:	↑ L I F T
(b) A private patient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>		D.O.B.:		D.O.B.:	
(c) A Medicare (public) patient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>					
(d) An outpatient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>					

<p>moaven+partners</p> <p>PATHOLOGY</p>	<p>Moaven &amp; Partners Pathology Pty Ltd                  24 Hope St Seven Hills 2147                  Tel: (02) 9624 6222 Fax (02) 9624 7620                  ABN 28 108 869 647 APA number 1043</p>	<p>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.</p>	<p>Medicare card number</p> <table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>										

Patient last name	Given name(s)	Sex	Date of birth	Your reference
Patient address	Post Code	Telephone home	Telephone work	

Tests requested

PATIENT COPY

Requesting doctor (surname and initials, address, provider number)

Patient status at time of the service or when specimen was collected:

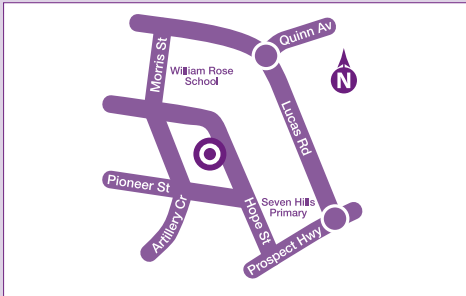
(a) A private patient in a private hospital or approved day hospital facility	Yes <input type="checkbox"/>	No <input type="checkbox"/>	↑ L I F T	NAME:	↑ L I F T	NAME:	↑ L I F T
(b) A private patient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>		D.O.B.:		D.O.B.:	
(c) A Medicare (public) patient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>					
(d) An outpatient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>					

(Practitioner use only)

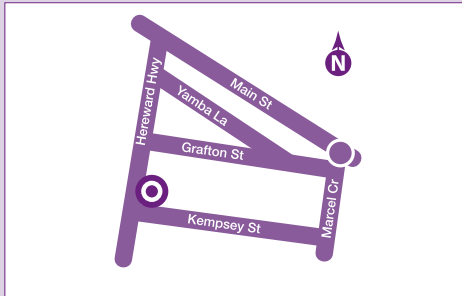
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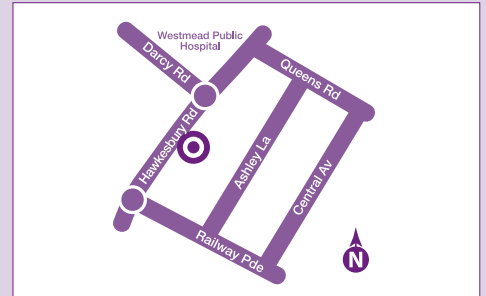
ALL PATIENTS BULK BILLED  
COLLECTION CENTRES



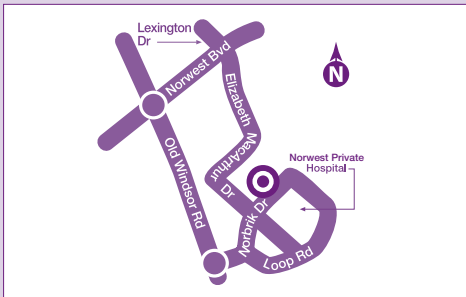
**SEVEN HILLS**  
24 Hope St (Opposite Seven Hills Primary)  
Tel: 9624 9100  
7.30am-7.30pm Mon-Fri, 8.00am- 2.30pm Sat



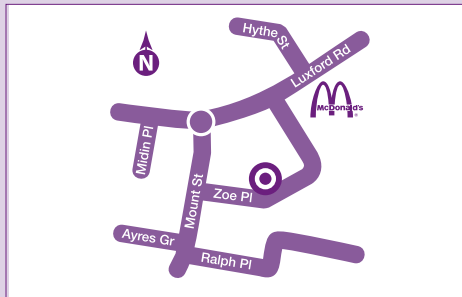
**BLACKTOWN**  
19 Hereward Hwy (Cnr Kempsey St)  
8.30am-5.30pm Mon-Fri



**WESTMEAD**  
Suite 305, (Level 3), 151-155 Hawkesbury Rd  
Tel: 9635 5445  
7.30am-3.30pm Mon-Fri, 8.00am-10.00am Sat



**BELLA VISTA**  
Q Medical Suite 105 (Level 1)  
Q-Central, 10 Norbrik Dr  
Tel: 8824 3800  
8.30am-4.30pm Mon-Fri



**MOUNT DRUITT**  
Shop T46, Shopsmart Outlet Centre  
1 Zoe Place  
Tel: 9625 2193  
7.30am-3.30pm Mon-Fri, 8.00am - 12.00noon Sat



**PATIENT FASTING INSTRUCTIONS**

For patients asked to 'fast' this means you **DO NOT** eat or drink anything except water for 8-16 hours prior to your test.

- During your fast you may drink water but no other fluids e.g. tea, coffee or cordial
- Ideally the blood is collected in the morning
- You should avoid smoking during the fasting period
- You should NOT fast for more than 16 hours
- Continue to take any medication unless advised otherwise by your doctor
- Diabetics should not fast without medical advice

**PATIENT INSTRUCTIONS FOR GLUCOSE TOLERANCE TEST**

- The patient should have an unrestricted diet containing at least 150 grams of carbohydrate per day for the three days prior to the test.
- Each of the foods listed below contain approximately 15 grams of carbohydrate.
 

1 banana, apple, pear or orange	½ cup cooked lentils
3 apricots	2 Arrowroot biscuits
6 prunes or dates	1 medium potato
½ cup rice	360mls of milk
1 slice of bread or crumpet	150mls fruit juice
3 Sao, Ryvita or Vita-wheat biscuits	½ cup cooked pasta
- At least 10 serves need to be eaten each day for 3 days before the test.
- It is worth noting that most people (not those on a weight loss program) would normally have over 150 grams of carbohydrate in their daily diet.
- You must fast for at least 8 hours but no more than 16 hours prior to the test.
- You are permitted to drink water ONLY during the fasting period.
- If you are taking medication on a permanent basis these should be continued. The only exception being cortisone type medication such as Prednisone, which should be omitted on the morning of the test.
- The test will take 2 hours to perform. You will have two blood tests.