Histopath
Diagnostic Specialists

Dr Chris Douglas
Dr Stephen Mann
RCPA NATA
Building B, Pinnacle Office Park
Suite 201, 4 Drake Avenue
Macquarie Park NSW 2113
Phone: (02) 9878 8111
Fax: (02) 9878 8300

Accredited for compliance with NPAAC Standards and ISO 15189
Accredited Laboratory Number: 13979 APL 39408
Douglas & Mann Pty Ltd (APA) ACN 076 987 007

MEDICARE CARD NUMBER

PATIENT DETAILS SURNAME | GIVEN NAME(S) | SEX | DATE OF BIRTH | YOUR REFERENCE

PHONE (H) | PHONE (M)

ADDRESS

TESTS REQUESTED

LABORATORY COPY

LAB USE

Self Determine

CLINICAL NOTES

URGENT ☐

Private ☐ Schedule ☐ Medicare ☐
Vet Affairs:

DOCTOR'S SIGNATURE & REQUEST DATE

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

COPY OF RESULTS TO (Surname, Initials, Address, Provider No.)

REQUESTED BY DOCTOR (Surname, Initials, Address, Provider No.)

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

	Y	N
A. Private patient in a private hospital or approved day hospital facility.	☐	☐
B. A private patient in a recognised hospital.	☐	☐
C. A public patient in a recognised hospital.	☐	☐
D. An outpatient at a recognised hospital.	☐	☐

PRACTITIONER'S USE ONLY
(Reason patient cannot sign)

.....

PATIENT'S SIGNATURE & DATE

I offer to assign my rights 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.

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

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.*

Your doctor has recommended that you use ***Histopath***. 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.

BEND FORM TO REMOVE LABELS

NAME:	NAME:	NAME:
D.O.B.:	D.O.B.:	D.O.B.:
LIFT	LIFT	LIFT

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SURNAME | GIVEN NAME(S) | SEX | DATE OF BIRTH | YOUR REFERENCE

ADDRESS | POSTCODE | PHONE (H) | PHONE (M)

TEST REQUESTED

DOCTOR (Surname, Initials, Address, Provider No.)

PATIENT COPY