SOUTH EASTERN AREA LABORATORY SERVICES

Excellence in diagnosis, research, teaching

ANDROLOGY REQUEST FORM

APPOINTMENT REQUIRED – Phone: (02) 9382 6643

NSW Health Pathology; APA 1142
SEALS Executive
Level 4 Campus Centre
Barker Street
Randwick NSW 2031

PATIENT DETAILS

Med. Rec. No: ..... **Ward:** .....

Hospital: .....

SURNAME: .....

FIRST NAME: .....

DOB: ...../...../..... Sex: .....

Address:..... Phone: .....

..... Postcode: .....

PARTNER DETAILS

Med. Rec. No: ..... **Ward:** .....

Hospital: .....

SURNAME: .....

FIRST NAME: .....

DOB: ...../...../..... Sex: .....

Address:..... Phone: .....

..... Postcode: .....

TESTS REQUESTED:

ROUTINE:

URGENT:

CONSULTANT: .....

REQUESTING PRACTITIONER

SURNAME: ..... Initials: .....

Phone: ..... Fax: ..... Pager No: .....

Address: .....

Postcode: ..... Provider No: .....

Signature **Date**

COPY OF REPORT TO

Name: .....

Address: .....

Postcode: ..... Phone/Fax: .....

COPY OF REPORT TO

Name: .....

Address: .....

Postcode: ..... Phone/Fax: .....

PROVISIONAL DIAGNOSIS:

SD ☐

CLINICAL NOTES:

SPECIMEN DETAILS:

(SEPARATE REQUEST FORM REQUIRED FOR EACH SPECIMEN)

TYPE OF SPECIMEN: .....

TIME & DATE OF COLLECTION: ..... : ..... am/pm ...../...../.....

♂ PREVIOUS EJACULATION DATE:..... : ..... am/pm ...../...../.....

♀ DAY OF MENSTRUAL CYCLE: .....

SAMPLE COLLECTED ON-SITE Yes ☐ No ☐

TRANSPORT CONDITIONS SATISFACTORY Yes ☐ No ☐

Your doctor has recommended that you use SEALS Pathology. 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.

Name of APP: .....

HOSPITAL STATUS Was or will the patient be, at the time of the service or when the specimen is obtained (please tick):

(a) a private patient in a private hospital or approved day hospital facility Yes ☐ No ☐

(b) a private patient in a recognised hospital Yes ☐ No ☐

(c) a public patient in a recognised hospital Yes ☐ No ☐

(d) an outpatient of a recognised hospital Yes ☐ No ☐

MEDICARE ASSIGNMENT **Medicare** ☐ **Vet Affairs** ☐

											REF
										–	

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 why patient cannot sign):

CONFIRMATION OF PATIENT/PARTNER DETAILS

I confirm that patient and/or partner details on this request are correct.

Signature: .....

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.

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