NEW SOUTH WALES TRANSPLANTATION AND IMMUNOGENETICS

Australian Red Cross Lifeblood

RCPA The Royal College of Pathologists of Australasia

NATA WORLD RECOGNISED ACCREDITATION

ASHI American Society for Histocompatibility & Immunogenetics www.ashi-hla.org

Enquiries
8:00am to 4:30pm
+61 2 9234 2322 (phone)
+61 2 9234 2326 (fax)

Sample Delivery (24 hours)
Dock A, Level 3 17 O'Riordan Street
Alexandria NSW 2015

ttreportingnsw@redcrossblood.org.au
www.transplantservices.com.au
Dr Jeremy McComish 230814JW

ASHI accreditation: 02-9-AU-01-1
NATA accreditation: 18808

Immunogenetics Request Form

PATIENT DETAILS **Please fill or affix hospital label here – three forms of ID required**

SURNAME (Please print) *	DOB *	MRN
GIVEN NAMES *		☐ FEMALE ☐ MALE
ADDRESS *		
REQUESTING DOCTOR *	PROVIDER No. *	CONTACT NUMBER *

REPORT TO	**COPY OF REPORT TO**
NAME *	NAME
ADDRESS *	ADDRESS
EMAIL* (institutional email address only)	EMAIL (institutional email address only)

TESTING REQUIREMENTS **Volume required: 10mL ACD or EDTA** (refer to website for sample volume for paediatric patients or patients with low cells counts)

CLINICAL NOTES *

LOCI TO BE TESTED (Please specify)

RESOLUTION (Please specify)

INVOICING (Testing for research, clinical trials or studies are *not approved* for Medicare rebate) **PLEASE INVOICE** ☐ Patient ☐ Requesting Doctor/Institute

PATIENT OR DELEGATE'S SIGNATURE (Confirming awareness that payment is required)

MEDICARE REBATE APPROVED TESTS **Please select from below list** (clinical testing only)

Adverse Drug Reaction susceptibility (ADR):			Behcet's disease	HLA-B*51	☐
Abacavir (ADR)	HLA-B*57:01	☐	Birdshot retinopathy	HLA-A*29	☐
Allopurinol (ADR)	HLA-B*58:01	☐	Goodpasture's syndrome/ anti-GBM	HLA-DRB1*15	☐
Carbamazepine (Tegretol) ADR	HLA-B*15:02	☐	Juvenile idiopathic arthritis	HLA-B*27	☐
Carbamazepine (Tegretol) ADR	HLA-A*31:01	☐	Narcolepsy	HLA-DQB1*06:02	☐
Dapsone (ADR)	HLA-B*13:01	☐	Psoriasis vulgaris	HLA-C*06	☐
Actinic prurigo	HLA-DRB1*04:07	☐	Reiter's disease/Reactive arthritis	HLA-B*27	☐
Acute anterior uveitis	HLA-B*27	☐	Rheumatoid arthritis	HLA-DRB1*04, B*27	☐
Ankylosing spondylitis	HLA-B*27	☐	Uveitis or Iritis	HLA-B*27	☐
Coeliac disease or Dermatitis Herpetiformis	HLA- DQB1*02,DQB1*03:02,DQA1*05	☐			

ACCOUNT TO BE SENT TO **Required to be completed for Medicare rebate only**

Please advise patient status at the time of service or specimen collection by circling/ticking A, B, C or D below and ticking the relevant patient box: ☐ **INPATIENT** ☐ **OUTPATIENT**

A ☐ Private patient in a private hospital or approved day hospital facility
B ☐ Private patient in a recognised hospital
C ☐ A public patient in a recognised hospital
D ☐ Outpatient of a recognised hospital

Medicare Assignment Form: 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. **Medicare Patient Choice Advisory Statement:** Your doctor has recommended that you use the Australian Red Cross Blood Service. 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.

MEDICARE No. ☐☐☐☐☐☐☐☐☐☐ REF No. EXPIRY DATE

PATIENT'S SIGNATURE DATE

PLEASE COMPETE FOR MEDICARE PAYMENT

PRACTITIONER'S USE ONLY Verbal consent was provided by patient to submit unpaid account to Medicare. No signature available. ☐

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.

SAMPLE COLLECTION **Recommended transportation:** Whole blood samples: Room temperature. Samples should be received by laboratory within 24hrs of collection. Ensure samples are packed in a secure container and the outside of the transport container is clearly labelled with the above delivery address.

COLLECTOR NAME	DATE AND TIME OF COLLECTION	ACCESSION No.
PATIENT'S SIGNATURE (Confirming samples have been labelled correctly)	DATE	

SPECIMEN TYPE ☐ WHOLE BLOOD (ACD) ☐ DNA ☐ OTHER (Please specify)

COMPLETED BY COLLECTOR