

SOUTH EASTERN AREA LABORATORY SERVICES

Excellence in diagnosis, research, teaching

www.seals.health.nsw.gov.au Phone 1800 073 257

See over for collection locations and contact details



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

PATIENT DETAILS	DO NOT USE THIS FORM FOR BLOOD BANK or TRANSFUSION REQUESTS
Med. Rec. No: Ward:	CLINICAL NOTES Pregnant: Yes No SD S
Hospital:	
SURNAME:	Kidney Transplant recipient with BK infection
FIRST NAME:	On actablished Araya (allow at least 4 weeks
DOB:/	On established Arava (allow at least 4 weeks of treatment to achieve stable levels after
Address: Phone:	load, target 50 to 100mg/L)
Postcode:	STG GEORGE SENDAWAY TO :
TESTS REQUESTED ROUTINE:	DEPT OF CLINICAL PATHOLOGY,
NOTINE.	QUEENSLAND HEALTH PATHOLOGY,
REQUEST: Plasma Teriflunomide Level	BRISBANE, QLD (Thursday sendaway day - turnaround 1 week)
(Leflunomide or "Arava" metabolite - A77 1726	Medication: Date/Time of last dose: Dosage:
	GYNAECOLOGICAL CYTOLOGY
Serum sample required:	Post Menopausal Pregnant Post Natal IUCD Abnormal Bleeding Radiotherapy
Collect in lithium heparin dark green or	Chemotherapy
red top (no gel) tube	NSW PAP TEST Register YES NO (If no, attach official sticker)
	Your doctor has recommended that you use SEALS Pathology. You are free to choose your own pathology provider. However, if
URGENT:	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.
"LIFE THREATENING" MUST CALL LAB Tick □	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):
CONSULTANT:	(a) a private patient in a private hospital or approved Yes □ No □
REQUESTING PRACTITIONER:	day hospital facility (b) a private patient in a recognised hospital Yes No No
Surname: Initials:	(c) a public patient in a recognised hospital Yes □ No □ (d) an outpatient of a recognised hospital Yes □ No □
Phone: Pager No: Pager No:	MEDICADE ASSIGNMENT: Madicara Vot Affaira
Address:	MEDICARE ASSIGNMENT: Medicare L. Vet Attairs L. REF
Postcode: Provider No:]
Signature Date	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
COPY OF REPORT TO:	service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner.
Name:	Patient Signature: Date:/
Address:	Practitioner's use only (Reason why patient cannot sign)
Postcode: Phone/Fax: COPY OF REPORT TO:	redution of doo only (nodes), my patient survey survey
Name:	CONFIRMATION OF PATIENT DETAILS
Address:	I confirm that patient details on this request and on all specimens collected are correct.
Postcode: Phone/Fax:	Patient/Carer's Signature:
COLLECTOR DECLARATION I certify that I collected the accompanying specimens from the above patient, whose identity was confirmed by enquiry and/or examination of their name band and that I labelled the specimens immediately following collection.	
Collector's Name: Signature:	
Collection Date:/ Collection Time: Sample Type/Site: Fasting: Yes / No CSR Initial:	
S/Gel Serum LiHop Grey EDTA Cong ESR Blood Blood Urine Fluid Swab Viral	CSF Histo Cyto Pap Stool Sput pLiHep pSerum pEDTA pGrey pCoag Other