PathCare

PRACTICE NO. 5200539

BARCODE STICKER

PATHOLOGY **REQUEST FORM**

If urgent, please complete below

Contact Person

Please tick no. supplied (✓) Tel ☐ Fax ☐ Cell ☐ Print ☐

LOCAL PATHOLOGISTS :
DRS DIETRICH, VOIGT, MIA PARTNERS

* **Referring Doctor** **FAT LOSS LABORATORY** **PathCare Code** **FATLOSØØ**

1st Copy Doctor (initials & surname) **Hospital & Ward**

2nd Copy Doctor (initials & surname) **3rd Copy Doctor** (initials & surname)

PATIENT DETAILS

File No.

* **Patient ID No./DOB**

* **Patient Surname** * **M** **F**

* **Patient First Name** * **Patient Title**

* **Tel. (h)** * **Cell**

* **Tel. (w)** * **E-mail**

I certify that the above information is correct and give specific consent for selected test(s) to be done. I authorise you to disclose these results to my medical aid administrators and/or insurance company. I undertake to pay all outstanding monies not covered by medical aid. I fully understand the implication of the test and have received adequate pre-test counselling.

SIGNATURE : PATIENT / GUARDIAN

SIGNATURE : PERSON RESPONSIBLE FOR PAYMENT IF DIFFERENT FROM PATIENT

* **Collected by** * **Date** DD MM YY Location code * **Time** :

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT (* compulsory - please complete)

* **Guarantor ID No.**

* **Title, Initials and Surname** Mr Mrs Ms Dr Prof

* **Postal Address**

* **Tel. (h)** * **Tel. (w)**

* **Cell**

* **E-mail**

* **Medical Aid** * **Medical Aid No.**

SPECIMEN INFORMATION

On Ice ☐ Venous ☐ Arterial ☐ No Cuff ☐ In Foil ☐ Other:

Site Priority S U H R Z

Received by , Date DD MM YY Time :

SPECIMEN INFORMATION AND COUNT **TEST COUNT**

URINE	HEPARIN	EDTA 4ml	EDTA 6ml	CITRATE	GEL	ACD	CLOTTED	FLUORIDE	OTHER - please specify	

Other Tests and Codes

Relevant Clinical Data and Present Medication

LMP D D M M Y Y Y Y FASTING (✓) YES NO

* ICD 10 CODE

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TESTS

G	B1023 ☐	GAMMA GT	P	G4489 ☐	HB/PCV	G	T1058 ☐	TSH
F	D1044 ☐	GLUCOSE fasting	G	A1038 ☐	LIPOGRAM fasting	G	N1001 ☐	U&E,CREATININE

NB: Patient on Eltroxin? (✓) YES ☐ NO ☐