

Women's & Children's Pathology



The Royal Women's Hospital
132 Grattan St Carlton 3053
APA
Royal Children's Hospital
Flemington Rd Parkville 3052

A/3314

LAB No

PATIENT Surname		Given Names	
Address			
			U.R. No.
Date of Birth	M/F	Gest/weeks	Telephone
		<input type="checkbox"/> Pensioner <input type="checkbox"/> TAC <input type="checkbox"/> VA	
IRN/Medicare No			
VA/TAC			
Account to			

CLINICAL NOTES (including medications please)	Fasting <input type="checkbox"/>

Transfusion Request <input type="checkbox"/> Irradiated <input type="checkbox"/> CMV Negative Required by Date _____ Time _____	Therapeutic Drug Request Drug _____ Dose _____ Freq. _____ Last Dose _____ O/IV _____
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Cervical cytology <input type="checkbox"/> Pre menopausal <input type="checkbox"/> Menopausal <input type="checkbox"/> Post menopausal <input type="checkbox"/> Pregnant Previous smear _____ LMP _____ Post Partum _____ Contraception _____ Hormone therapy _____	Was or will patient be, at the time of the service or when the specimen is obtained: Yes No (a) a private patient in a private hospital or approved day hospital facility <input type="checkbox"/> <input type="checkbox"/> (b) a private patient in a recognised hospital <input type="checkbox"/> <input type="checkbox"/> (c) a Medicare (public) patient in a recognised hospital <input type="checkbox"/> <input type="checkbox"/> (d) an outpatient of a recognised hospital <input type="checkbox"/> <input type="checkbox"/>
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Requesting Doctor: Surname, Initials and Provider No.
Pager No:
Contact for Actionable Results:
Consultant Unit (RCH):
Copy to: (Dr's name and address)
<input type="checkbox"/> RWH (Circle) Ward/location (Circle) R3X <input type="checkbox"/> RCH OP IP NHP C W G M <input type="checkbox"/>
Urgent by (Time) Contact No Tel..... Fax.....
Sample <input type="checkbox"/> Capillary <input type="checkbox"/> Venous <input type="checkbox"/> Arterial

TESTS REQUESTED
Doctor's Signature _____ Request Date _____

LAB USE ONLY	
GAS	
GEL	
EDTA-HAEM	
EDTA-BB	
CITRATE	
HEP	
FLOX	
ACD	
MSU	
RAND URINE	
24hr URINE	
CSF	
SLIDE	
SWAB	
FAECES	
FLUID	
BLCU	
OTHER (SPECIFY)	
PROC CODES	

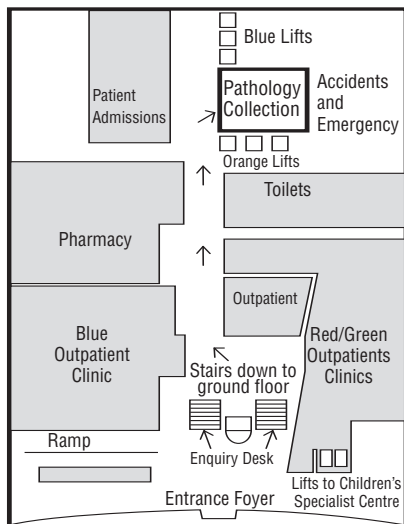
I certify that the accompanying specimen was collected from the patient stated above as ascertained by inquiry and/or examination of name band and was labelled immediately following collection.

Signed _____ Print Name _____ Date _____ Time _____

Collection Centres

Royal Children's Hospital
Ground Floor
Hours: 08.30 - 16.50 Monday - Friday
 09.00 - 10.00 Saturday (by appointment only)
Phone: 9345 5821
Facsimile: 9345 5379

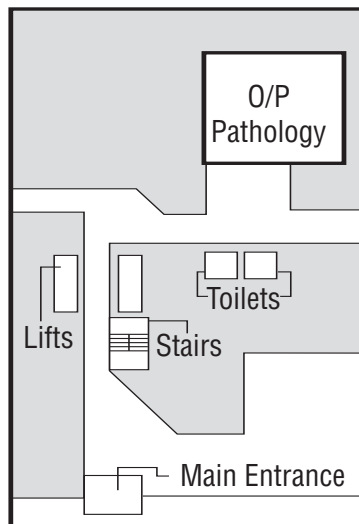
The Royal Children's Hospital Ground Floor



Flemington Road Entrance

The Royal Women's Hospital
Ground Floor
Hours: 08.30 - 17.30 Monday, Wednesday, Thursday
 08.30 - 18.00 Tuesday
 08.30 - 14.00 Friday
Phone: 9344 2090

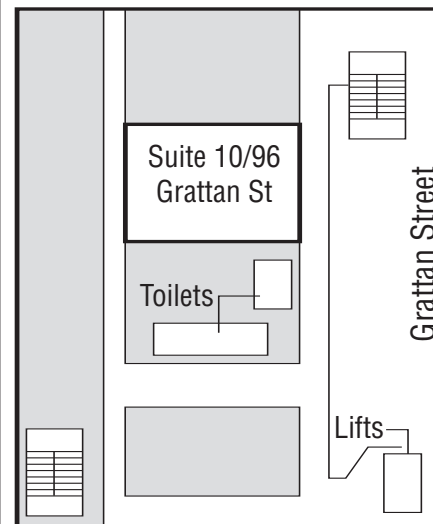
The Royal Women's Hospital Ground Floor



Grattan Street

Level 7
Suite 10/96 Grattan Street
Hours: 08.30 - 17.30 Monday - Friday
Phone: 9344 3669
Facsimile: 9344 3681

Level 7 Suite 10/96



Cardigan Street