

Lab Number

Don College



HOBART
PATHOLOGY
LAUNCESTON
PATHOLOGY
NORTH WEST
PATHOLOGY
Quality is in our DNA

PATHOLOGY REQUEST FORM

Special Testing

Patient Details

Title: Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐

Surname: _____ Given Name: _____ Mobile: _____

Date of Birth: ____/____/____ Gender: Male ☐ Female ☐

Address:

C/O Don College
87 Watkinson St
Devonport

Requesting Doctor: C1995

Add Copy Doctor: T1500

Dr Jane Cooper

Prov No 202562H

Pay Cat: **Bulk Bill** Medicare Number _____ (Compulsary field)

Tests Requested:

Chlamydia
Gonorrhoeae

No other tests to be added to this request form

Office Use Only

CHU
NGU

Special Instructions:

Do not void in hour prior to collection. The initial part of the void must be collected
(Not Midstream). This applies to both males and females. Urine volume required = 50ml

Sample must be collected and dropped off within 24hrs

Please put the date and time on the urine container.

Doctor Signature NOT required

For Laboratory Use

Staff Initials:

Loc Code:

Type of collect: UHDS

I certify that the pathology specimen accompanying the request was collected from the patient stated above.

Signature of person collecting specimen _____

Date of Collect: ____/____/____

Time of Collect: _____