Lab Number

Don College

PATHOLOGY REQUEST FORM — Special Testing

Patient Details

TItle: Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐

Surname:____________________________ Given Name:______________ Mobile: ______________

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

Address:

Don Medical Clinic
48-54 Oldaker Street
Devonport

Requesting Doctor: **C1995**
Dr Jane Cooper
Prov No 202562RF

Add Copy Doctor: **T1500**

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: ________