



**PATHOLOGY REQUEST FORM**  
**Microbiological Diagnostic Unit Public Health Laboratory**  
 at Melbourne Sexual Health Centre  
 Department of Microbiology and Immunology, University of Melbourne, VIC 3010  
 Melbourne Sexual Health Centre Laboratory 9341 6220, Main Lab 8344 5701/5713  
 Email: [publichealth.lab@mdu.unimelb.edu.au](mailto:publichealth.lab@mdu.unimelb.edu.au)  
 Director: Prof. Benjamin Howden, MBBS, FRACP, FRCPA, PhD, 206527 RL



NATA/RCPA Accredited Laboratory No. 1019

<i>Surname</i>	<i>Given Name</i>	<i>Sex</i>	<i>Date of Birth</i>
<i>URNo</i>	<i>Name Code</i>	<i>Medicare Card Number</i>	
<i>Patient Address</i>		<i>Telephone</i>	

<i>Test Requested</i>	<i>Patient status at the time of the service or when the specimen was collected:</i>	
		<i>yes</i> <i>no</i>
	<i>Private patient in a private hospital or approved day hospital facility</i>	<input type="checkbox"/> <input checked="" type="checkbox"/>
	<i>Public patient in a recognised hospital</i>	<input type="checkbox"/> <input checked="" type="checkbox"/>
	<i>Private patient in a recognised hospital</i>	<input type="checkbox"/> <input checked="" type="checkbox"/>
	<i>Outpatient of a recognised hospital</i>	<input type="checkbox"/> <input checked="" type="checkbox"/>

*Clinical Notes*

SD (self determined)

*Requesting Doctor's Signature and Request Date*

Date:

Signature: X DOCTOR

PERSON COLLECTING SPECIMEN(S) TO COMPLETE: I certify that the Pathology specimen accompanying this request was collected from the patient stated above as established by direct enquiry.	Your doctor has recommended that you use Microbiological Diagnostic Unit. You are free to choose your own pathology provider. However, if 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.
	Medicare Agreement (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 the practitioner.
Signature: X COLLECTOR      Date:	Patient Signature: X PATIENT
Name:      Time:	Date:
Practitioner Use Only (Reason patient cannot sign)	

Privacy Note: The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of government health programs, and may be used to update enrolment records. Its collection is authorised by the provisions of the Health Insurance Act 1973. The information may be disclosed to the Department of Health or to a person in the medical practice associated with this claim, or as authorised/required by law.