www.metropath.com.au | reception@metropath.com.au
378-380 Johnston Street, Abbotsford, VIC, 3067
Phone 03 9421 1399 | Fax 03 9421 0699
ABN 52111728137

The Royal College of Pathologists of Australasia
Accredited for compliance with NPAAC standard and ISO 15189
MP_R02_A5RP_23

Patient Title: Surname: Given Name(s):

Patient Address:

Date of Birth:

Phone:

Medicare No: Issue: Ref:

Sex:

Requesting Doctor's Surname, Initials, Address, Provider No.:

MEDICARE ASSIGNMENT: (Section 20A of the *Health Insurance Act 1973*) By this declaration I 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.

Practitioners Use Only:

(reason patient cannot sign) Patient Signature Date

Copy of Reports to:

Clinical Notes:

Bulk Bill: ☐

Self Determine: ☐

Tests Requested:

Doctor's Signature: Date:

Lab Use:

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 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.

Patient Advisory Statement: Your treating practitioner has recommended that you use Metropath. You are free to choose your own pathology provider. However, if your treating practitioner has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service(s). You should discuss this with your treating practitioner.

Patient Status at specimen collection or date of service:

	YES	NO
Private patient in a private hospital or approved day hospital facility	☐	☐
Private patient in a recognised hospital	☐	☐
Public patient in a recognised hospital	☐	☐
Outpatient in a recognised hospital	☐	☐

COLLECTOR'S DECLARATION: I certify that the pathology specimen accompanying the request was collected from the patient stated above as established by direct enquiry and/or inspection of wrist band.

Collector's Signature: Date: Time: