

DO NOT BULK BILL
Request to be pre-paid at time of collection by Credit Card ONLY.

**PATIENT
SELF REQUEST FORM**

PATIENT FAMILY NAME	GIVEN NAMES	SEX	DATE OF BIRTH	FILE No.
PATIENT ADDRESS			TEL (HOME & MOBILE)	TEL (BUS)
POSTCODE				

TESTS REQUESTED

Patient self request - PRIVATE & CONFIDENTIAL

Is patient: Fasting
Non Fasting

Please tick test/s you require:

- Hair Drug Screen
- Carbohydrate Deficient Transferrin (CDT)

QML Pathology Use:

Request must be PRE-PAID AT TIME OF COLLECTION by Credit Card ONLY Pre-Paid Receipt Number: _____

Photo Identification Sighted:

Drivers License Passport Other: _____ ID Number: _____

The appropriate Chain of Custody form **MUST** be completed for the above tests. Collector must tick box below to confirm form has been completed.

- Hair Drug Screen Chain of Custody completed
- Carbohydrate Deficient Transferrin (CDT) Chain of Custody completed

Consult patient and complete below - TICK ONE OPTION ONLY:

- Laboratory report delivered to Patient address as indicated on this request form. (Note: Patient Results **CANNOT** be emailed)
- Laboratory report to be picked up from this Collection Centre by patient*:

ACC code: _____ ACC phone number: _____

*Advise patient to CALL COLLECTION CENTRE prior to picking up laboratory report (photo identification will be required).

COLLECTOR DECLARATION (Tick where applicable)

I certify: The results documented on this form are from the sample provided to me by the Donor who has given signed certification below.

- The specimen has been collected in compliance with the requirements of the Standard (AS4308).
- I hold a Certificate in Specimen Collection that includes Drugs of Abuse testing.

COLLECTOR NAME: COLLECTOR SIGNATURE: DATE:/...../.....

PATIENT'S SIGNATURE AND DATE

I confirm that the information provided on this form by myself to QML Pathology is true and correct. I understand that I will receive a copy of this form and that a laboratory report will be delivered in the method indicated above. I have read and understood the disclaimer at the bottom of the page.

X...../...../.....

PATIENT'S SIGNATURE DATE

REQUESTING DOCTOR, WORKPLACE HEALTH AND SAFETY OFFICER

PATIENT SELF REQUEST CPS2N
QML Pathology
Doctor Maintenance Department
11 Riverview Place
MURARRIE QLD 4172

Disclaimer: QML Pathology advises that pathology tests are usually requested by a patient's doctor as they are medically qualified to interpret and/or analyse the results. QML Pathology offers a limited range of self requested pathology tests because some panels of testing are complex and there may be the possibility of misinterpretation of pathology results in the absence of medical symptoms discussed as part of a medical consultation. Patients requesting self determined testing will need to consult their local medical professional if they require interpretive advice.

L U A S E	Collect Date	Coll. Time	Test Codes	Branch	Ref. No.	Lab. No.	Description & Containers	Collector
	Received Date	Rec. Time		B/C	Clinic			
				PP				