QML Pathology

Specialist Diagnostic Services Pty Ltd (ABN 84 007 190 043) t/a QML Pathology APA No.000042
11 Riverview Place, Metroplex on Gateway, Murarrie, Qld, 4172. Ph (07) 3121 4945

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	POSTCODE	TEL (HOME & MOBILE)	TEL(BUS)

TESTS REQUESTED

Patient self request - PRIVATE & CONFIDENTIAL

On-Site Instant Saliva Drug Screen (DS6)

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: _____

Testing Device Name:..... Batch Number:..... Expiry Date: / /

Drug Class	Amphetamines	Cocaine	Opiates	THC	Other/Specify
Aust Std (AS4760) Target Value	50 ng/mL	50 ng/mL	50 ng/mL	25 ng/mL	
Cut-off Level (ng/mL) (if different to Aust Std)					
Initial Test Result					
Key: N = Negative U = Unconfirmed Positive (requires confirmatory testing)					

☐ **Patient requests Laboratory Mass Spectrometry Confirmation to comply with AS4760**
Must be paid before specimen sent to laboratory otherwise test will NOT be performed.

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 (AS4760).

☐ 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 with the initial screening results 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.

✗..... ...../...../.....
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.

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LAB USE	Collect Date / Received Date	Coll. Time / Rec. Time	Test Codes	Branch / B/C	Ref. No. / Clinic	Lab. No.	Description & Containers	Collector
				PP				