Dorevitch® PATHOLOGY

Lab No

ilac-MRA RCPA The Royal College of Pathologists of Australasia NATA
Accreditation Number 2204
Accredited for compliance with NPAAC standards and ISO 15189

REGULAR WARFARIN PATIENT (INR)

PATIENT LAST NAME	GIVEN NAME	SEX	DATE OF BIRTH	YOUR REF:
ADDRESS		TELEPHONE (HOME)		TELEPHONE (BUS)
MEDICARE CARD NUMBER - CRN		MOBILE		

REQUESTING PRACTITIONER (Surname & Initials, Address, Telephone & Provider No.)	COPY REPORTS TO (Surname & Initials, Address, Telephone & Provider No.)
NURSING HOME / HOSTEL	

CURRENT WARFARIN DOSE	Location		Fee Cat	Test Panel	Received by
Daily ☐ Alternating ☐ Week/Weekend ☐		V ☐ N ☐		INR	
Monday - Saturday ☐ Sunday ☐ ___ mg		H ☐ O ☐			
		C ☐ P ☐			

REGULAR PROTHROMBIN **IF OUR DOSE PUT 'X'** ☐

IF DOCTOR DOSE PUT 'X' IN BOX ON RIGHT

DOCTOR DOSING ☐	FOR DATA ENTRY
INPATIENT – HSPH	Y
WARD	
CURRENT DOSE	NA
TRACKING	N

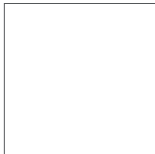
1. RELEVANT CHANGES SINCE YOUR LAST TEST:

a) MEDICATION CHANGES
If YES, Provide Details ....

b) HOSPITAL STAY If YES, From ☐☐/☐☐/☐☐ To ☐☐/☐☐/☐☐
Provide Details ....

c) MEDICAL PROCEDURES
If YES, Provide Details ....

d) DENTAL WORK
If YES, Provide Details ....



e) OTHER
If YES, Provide Details ....

f) HAS YOUR WARFARIN BEEN WITHHELD OR DOSE CHANGED BY **ANYONE OTHER THAN DOREVITCH PATHOLOGY?**
Provide Details ....

2. SINCE LAST TEST HAVE YOU HAD:

a) INCREASED BRUISING? If YES, State Mild ☐ Moderate ☐ Severe ☐ Site .... Date ....

b) ANY BLEEDING? If YES, State Mild ☐ Moderate ☐ Severe ☐ Site .... Date ....

3. DATE WARFARIN COMMENCED (IF KNOWN): ☐☐/☐☐/☐☐

4. OTHER RELEVANT INFORMATION: ....

....

Specimen Collected - 24hr clock
DATE ☐☐☐☐☐☐
TIME ☐☐:☐☐

MEDICARE ASSIGNMENT (Section 20A of the Health Insurance Act 1973)
I offer to assign my right to benefits to the approved pathology practitioner ("APP") who will render the requested pathology services and any eligible pathologist determinable service(s) established as necessary by the practitioner. In the event that I am issued an account for those services, I also authorise that APP to submit my unpaid account to Medicare so that Medicare can assess my claim and issue me a cheque payable to the APP for the Medicare Benefit.

Practitioner's Use Only X.................... X.................... / /
(Reason patient cannot sign) (Patient's Signature) (Date)

PERSON DRAWING BLOOD: I certify that the blood specimen(s) accompanying this request was drawn from the patient named above and I established the identity of this patient by direct inquiry and/or by inspection of wrist band, and immediately upon the blood being drawn I labelled the specimen(s). This signature also acknowledges the collection of all other specimens.

Surname (print) .... Signed ....

Specialist Diagnostic Services, ABN 84 007 190 043 APA No. 000042, trading as Dorevitch Pathology. DP0424V3 30.01.17