

|                   |             |                                                                                                                       |          |                   |           |
|-------------------|-------------|-----------------------------------------------------------------------------------------------------------------------|----------|-------------------|-----------|
| PATIENT LAST NAME | GIVEN NAMES | INDIGENOUS STATUS<br><input type="checkbox"/> ABORIGINAL <input type="checkbox"/> TSI<br><input type="checkbox"/> N/A | SEX      | DATE OF BIRTH     | FILE No.  |
| PATIENT ADDRESS   |             |                                                                                                                       | POSTCODE | TEL (HOME/MOBILE) | TEL (BUS) |

|                 |                                         |                                            |
|-----------------|-----------------------------------------|--------------------------------------------|
| TESTS REQUESTED | Self Determine <input type="checkbox"/> | Fasting Req'd <input type="checkbox"/>     |
|                 |                                         | Non fasting Req'd <input type="checkbox"/> |
|                 |                                         | Warfarin <input type="checkbox"/>          |
|                 |                                         | Pregnant <input type="checkbox"/>          |
|                 |                                         | Horm Therapy <input type="checkbox"/>      |

COLLECTOR TO SIGN DECLARATION BELOW

CLINICAL NOTES/MEDICATIONS (State specimen type and site)

|                                        |                                       |                                             |          |                                                             |
|----------------------------------------|---------------------------------------|---------------------------------------------|----------|-------------------------------------------------------------|
| <b>URGENT</b> <input type="checkbox"/> | <b>PHONE</b> <input type="checkbox"/> | <b>FAX</b> <input type="checkbox"/>         | BY TIME: | RB/DB Category:                                             |
| PHONE/FAX No:                          |                                       |                                             |          | <input type="checkbox"/> Pens <input type="checkbox"/> HCC  |
| PRIVATE <input type="checkbox"/>       | SCHEDULE FEE <input type="checkbox"/> | REBATE/DIRECT BILL <input type="checkbox"/> |          | <input type="checkbox"/> SCARD <input type="checkbox"/> DVA |
| VET AFFAIRS                            |                                       |                                             |          |                                                             |

DOCTOR'S SIGNATURE AND REQUEST DATE

...../...../.....

For Crossmatch/Group & Hold Serum/Blood Product Ordering:

|                                      |
|--------------------------------------|
| Blood Group .....                    |
| Antibodies .....                     |
| Anti D in last 3 months? Yes/No      |
| Pregnancy in last 3 months? Yes/No   |
| Transfusion in last 3 months? Yes/No |
| Hospital .....                       |
| Ward .....                           |
| Date Required .....                  |
| Time ..... am/pm                     |

|                 |                                                         |                                                                                      |
|-----------------|---------------------------------------------------------|--------------------------------------------------------------------------------------|
| COPY REPORTS TO | REQUESTING DOCTOR/SURNAME/INITIALS/ADDRESS/PROVIDER No. | HOSPITAL STATUS<br><small>(Tick if applicable)</small>                               |
|                 |                                                         | Was or will the patient be, at the time of service or when the specimen is obtained: |
|                 |                                                         | <input type="checkbox"/> a private patient in a hospital                             |
|                 |                                                         | <input type="checkbox"/> a public patient in a hospital                              |
|                 |                                                         | <input type="checkbox"/> an outpatient of a recognised hospital                      |
|                 |                                                         | .                                                                                    |

CC Mater South Brisbane Medical Records

COLLECTOR DECLARATION

I certify that I have collected the accompanying sample from the above patient whose identity was confirmed by enquiry and/or examination of their name band and that I have labelled the sample immediately following collection.

Signature

|                |             |
|----------------|-------------|
| Staff Payroll: | Print Name: |
|----------------|-------------|

|                                                                                                                                         |               |                  |
|-----------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------|
| Collection Date                                                                                                                         | Containers    | Hosp/NH/Day Surg |
| Time                                                                                                                                    |               |                  |
| Fasting State at TOC<br><input type="checkbox"/> 8-12 hrs<br><input type="checkbox"/> 13-16 hrs<br><input type="checkbox"/> Non Fasting | Collect Stamp | Ward             |

**MEDICARE ASSIGNMENT** (Section 20A of the Health Insurance Act, 1973) I offer to assign my rights 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.

**ACCOUNT DECLARATION** Should any of the tests requested by my doctor not be eligible for Medicare benefits, I understand that I will receive an account for these tests and agree to pay in full.

|                                                            |             |
|------------------------------------------------------------|-------------|
| PATIENT SIGNATURE: .....                                   | DATE: ..... |
| Practitioner's Use Only (Reason patient cannot sign) ..... |             |

PATIENT DETAILS

TESTS REQUESTED

|                   |           |
|-------------------|-----------|
| DATE OF BIRTH     | MEDICARE  |
|                   | FILE No.  |
| TEL (HOME/MOBILE) | TEL (BUS) |

REQUESTING DOCTOR/SURNAME/INITIALS/ADDRESS/PROVIDER No.



**Mater Laboratory Services** APA 000526

**Mater Misericordiae Health Services Brisbane Limited** ACN 096 708 922

## Mater Pathology Collection Centres

### Albany Creek

Shop 21, 700 Albany Creek Road,  
Albany Creek 4035  
Phone: 07 3163 5233

### Alexandra Hills

71 Cambridge Drive, Alexandra Hills 4161  
Phone: 07 3163 5304

### Beenleigh

4/54 George Street, Beenleigh 4207  
Phone: 07 3163 5308

### Bethania

1/13-15 Glasson Drive, Bethania 4205  
Phone: 07 3163 5602

### Blackstone After Hours Clinic

2A/14 Hill Street, Blackstone 4304  
Phone: 07 3163 5850

### Blackstone HelloDr

1/12 Hill Street, Blackstone 4304  
Phone: 07 3163 5892

### Brookwater

Level 1, Mater Health Centre,  
2 Tournament Drive, Brookwater 4300  
Phone: 07 3199 3250

### Calamvale

Shop 5B, 668 Compton Road,  
Calamvale 4116  
Phone: 07 3163 5890

### Chermside

Ground Floor, St. Vincent's Northside  
Private Hospital,  
Rode Road, Chermside 4032  
Phone: 07 3163 1497

### Cleveland

3/12 Doig Street, Cleveland 4163  
Phone: 07 3163 5369

### Cleveland

Suite 13, Mater Medical Centre  
Specialist Suites,  
41 Weippin Street, Cleveland 4163  
Phone: 07 3163 7350

### Coorparoo

174 Cavendish Road, Coorparoo 4151  
Phone: 07 3163 6571

### Fortitude Valley

James St Pharmacy, 5 James Street,  
Fortitude Valley 4006  
Phone: 07 3163 5616

### Goodna

31 Church Street, Goodna 4300  
Phone: 07 3163 5890

### Inala

119 Biota Street, Inala 4077  
Phone: 07 3163 5312

### Karara Downs

1 Langi Court, Karara Downs 4306  
Phone: 07 3163 5300

### Keppera

Great Western Super Centre  
Cnr Samford Road and Settlement  
Road, Keppera 4054  
Phone: 07 3163 5348

### Macleay Island

14 Brighton Road, Macleay Island 4184  
Phone: 07 3163 5331

### Marsden

15 Barklya Place, Marsden 4132  
Phone: 07 3163 5247

### Mt Ommaney

Shop 97, Mt Ommaney Shopping Village,  
171 Dandenong Road, Mt Ommaney 4074  
Phone: 07 3163 5258

### Oxley

Grow Medical,  
169 Seventeen Mile Rocks Road, Oxley 4075  
Phone: 07 3163 8509

### Ripley

T20a/20 Main Street, Ripley 4306  
Phone: 07 3163 5220

### Redbank Plains Mountview

Mt. View Doctors, T12-191 Cnr School Road  
and Mount Jullierat Street, Redbank Plains  
Phone: 07 3163 5254

### Russell Island

2 Alison Crescent, Russell Island 4184  
Phone: 07 3163 7316

### Sherwood

9/600 Sherwood Road, Sherwood 4075  
Phone: 07 3163 5328

### Salisbury

6/660 Toohey Road, Salisbury 4107  
Phone: 07 3163 5861

### Samford

Doctors at Samford Valley,  
Shop 4-5, 39 Main Street  
Phone: 07 3163 5851

### Silkstone

Silkstone Village,  
Cnr Blackstone and Grange Road,  
\Silkstone 4304  
Phone: 07 3163 5288

### South Brisbane

Level 6, Mater Private Hospital Brisbane,  
301 Vulture Street, South Brisbane 4101  
Phone: 07 3163 7625

### South Brisbane

Level 4, Mater Hospital Brisbane,  
Raymond Terrace, South Brisbane 4101  
Phone: 07 3163 8732

### South Brisbane

Level 2 Salmon Building, 537 Stanley Street,  
South Brisbane 4101  
Phone: 07 3163 2708

### Springfield

Level 2, Mater Private Hospital  
30 Healthcare Drive, Springfield 4300  
Phone: 07 3098 3975

### Springfield Hub

95 Southern Cross Circuit, Springfield  
Central 4300  
Phone: 07 3163 5386

### Springfield Orion

Shop 1.6A Level 1 Orion Shopping Centre,  
Cnr Centenary Highway and Springfield  
Greenbank Arterial Road, Springfield 4300  
Phone: 07 3163 5329

### Springfield Wellness

103/2 Wellness Way, Springfield 4300  
Phone: 07 3163 5380

### Sunnybank Hills

Sunnybank Hills Shopping Town,  
Cnr Calam Road and Compton Roads,  
Sunnybank Hills 4109  
Phone: 07 3163 6597

### Thorndlands

128-144 Boundary Road, Thorndlands 4164  
Phone: 07 3163 5365

### Underwood

Watersprings Health Centre  
2 Springvale Circuit, Underwood 4119  
Phone: 07 3163 5358

### Wynnum

Wynnum Medical Centre, Shop 7,  
1795 Wynnum Road, Tingalpa 4173  
Phone: 07 3163 5338

### Yamanto

512-514 Warwick Road, Yamanto 4305  
Phone: 07 3163 5302

### Zillmere

41-45 Handford Road, Zillmere 4034  
Phone: 07 3163 5361



## Celebrating Over 100 Years of Service