Molecular Pathology Request Form

ACT PATHOLOGY

Your doctor recommended that you use ACT Pathology. You are free to choose your own pathology provider. However if your doctor has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor.

NATA ACCREDITED FOR TECHNICAL COMPETENCE

RCPA The Royal College of Pathologists of Australasia

PATIENT DETAILS

Surname: _____ Male

First Name: _____ DOB: ____/____/____

Address: _____

_____

Medicare No:

☐☐☐☐ ☐☐☐☐☐ ☐ ☐ IRN

Patient's Health Fund: _____

Fund No: _____

LABORATORY INFORMATION

Originating Pathology Lab: _____

Lab Episode & Block No: _____

Primary Tumour Diagnosis: _____

_____

Other Clinical History: _____

_____

REQUESTING CLINICIAN / PATHOLOGIST

Name: _____

Address: _____

_____

Provider No:

Tel: _____ Mobile: _____

Fax: _____

Email: _____

Authorised signature _____

Date of request: ____/____/____

Analysis by other Pathology Service permitted ☐

COPY DOCTOR

Name: _____

Address: _____

_____

Fax: _____

Select Single Test and Payment Option

☐ **EGFR**	☐ **Medicare:** *NSCLC (non squamous histology not otherwise specified) for access to erlotinib or gefitinib under the PBS.* ☐ **Bill patient** *(Must discuss with patient first. Provide billing details).* ☐ **Other:** _____
☐ **BRAF**	☐ **Medicare:** *Unresectable stage III or stage IV metastatic cutaneous melanoma for access to dabrafenib Under the PBS.* ☐ **Bill patient** *(Must discuss with patient first. Provide billing details).* ☐ **Other:** _____
☐ **KRAS**	☐ **Medicare:** *Metastatic colorectal cancer for access to cetuximab under the PBS.* ☐ **Bill patient** *(Must discuss with patient first. Provide billing details).* ☐ **Other:** _____
☐ _____ **(other)**	☐ **Bill patient** *(Must discuss with patient first. Provide billing details).* ☐ **Other:** _____

Medicare Assignment Form

(Section 20A of the HIA 1973)

I offer to assign my right to benefits to the approved practitioner who will render the requested service(s) and any eligible pathological determinable service(s) established necessary by the practitioner.

Patient Signature _____ Date ____/____/____

PRACTITIONER'S USE ONLY

(Reason patient cannot sign) _____

If a test is being requested through Medicare, the patient's hospital status at the time of the service or when the specimen was collected is required:

- ☐ Private patient in a public hospital, or approved day hospital facility
- ☐ Private patient in a recognised hospital
- ☐ Public patient in a recognised hospital
- ☐ Outpatient of a recognised hospital

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 provision of the Health Insurance Act 1973. The information may be disclosed to the Department of Health and Aging or to a person in the medical practice associated with this claim, or as authorised/required by law.

Please scan & send the completed form to Molecular@act.gov.au
or Fax: 02 6244 2892

ACT Pathology Department of Anatomical Pathology
Attn: Kate Bareis, PO Box 11, WODEN ACT 2606
Ph: 6244 2867