Print Form

Pathology Queensland

Queensland Government

DOCTORS: Please complete ALL relevant areas in the red section

Patient Details

FACILITY

GENDER UR PREFIX UR NO DATE OF BIRTH

M F

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PATIENT SURNAME (Please print or place sticker on this area) PATIENT FIRST NAME

PATIENT ADDRESS

Medicare Details

Patient status at the time of the service or when specimen collected (please tick) Yes

- Private patient in a private hospital or approved day hospital facility
- Private patient in a recognised hospital
- Public patient in a recognised hospital
- Outpatient in a recognised hospital

PHLEBOTOMY USE ONLY

MEDICARE NUMBER

HEALTH FUND NAME

VETERANS AFFAIRS IRN

Indigenous status

Aboriginal TSI Both Non Indigenous Not stated

MEDICARE ASSIGNMENT FORM (Section 28A 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

Patient Signature X Date / /

PRACTITIONERS USE ONLY (Reason patient cannot sign)

Birth Hospital Info

HOSPITAL REGISTRATION DETAILS

Hospital of Birth

Surname Child Date Of Birth

Given Names Child Gender

UR Numberof Child

Surname Mother

Given Names Mother

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

REC'D TIME INITIALS

I have signed the above assignment to elect to have my pathology services bulk billed to Medicare. Code CONVM Billing Cat PA

Your doctor has recommended that you use Pathology Queensland. 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.

Request Details

LAB NO

WARD/ CLINICAL UNIT

LAB USE ONLY

TEST REQUESTED

CMV PCR testing from Newborn Screening Card

CMVPCR

No other testing can be ordered on this form

CLINICAL NOTES/MEDICATIONS GESTATIONAL AGE K=

Permanent Hearing Loss? Yes No

Diagnostic Audiology Service*:

*Queensland Health Healthy Hearing program will only fund testing that is within program criteria. If this information is not indicated, the patient may be privately billed.

Address of Requesting Practitioner*:

Doctor

CONSULTANT/SENIOR MEDICAL OFFICER SURNAME (Please print) INITIALS

SURNAME OF REQUESTING DOCTOR (Please print) AUSLAB CODE

FIRST NAME PROVIDER NUMBER

Requesting Doctor's Signature X Date Requested / / Self Determine

URGENT TEL PAGE FAX CONTACT NO

Copy

COPY REPORT TO: SURNAME (Please print) INITIALS

COPY REPORT TO ADDRESS

Parental / Guardian Consent:

I, (mother/father/guardian) give permission for a blood spot from the Newborn Screening Card of the above mentioned child, which was collected on the birth of the abovementioned child and is currently held by the Newborn Screening Unit of Pathology Queensland, to be released to the Molecular Diagnostic Unit, Pathology Queensland and to be tested for Cytomegalovirus nucleic acid. I understand that the Healthy Hearing Program will be notified of the results and I may be contacted by staff associated with the Healthy Hearing Program. I also understand that de-identified data may be used for statistical reporting and research purposes. In signing this form, I confirm that I am the next of kin or the legal guardian of the child and the child has been diagnosed with a permanent hearing loss. I also acknowledge that the Molecular Diagnostic Unit will return the Newborn Screening Card and any unused specimens to the Newborn Screening Unit on completion of the test and that the specimen will not be used for any other testing without the written permission of the child's next of kin or legal guardian. I understand that although the identification of Cytomegalovirus nucleic acid on this test may indicate a possible cause of the child's permanent hearing loss it does not exclude other possible causes of the permanent hearing loss and that other testing may also be recommended for the child. I may be contacted if the Newborn Screening Card is not located using the information above

Signature (mother/father/guardian) ..... **Date** ..... ./..... ./..... **Contact Number**.....

The Healthy Hearing program will only accept the expenses of CMV PCR testing from Newborn Screening Card for children who are: 1) Diagnosed with permanent hearing loss and 2) 5 years or younger. If outside these criteria please invoice privately.

Signature (mother/father/guardian) ..... **Date** ..... ./..... ./..... **Billing Address**.....

Service	Funding Currently Available (subject to eligibility)	Cost if Unfunded
CMV PCR Testing	Healthy Hearing Program	$46.44
Screening Card Retrieval	Healthy Hearing Program	$40.50

Requesting Practitioner's Statement:

- I have explained to the mother/father/guardian the testing procedure, its purpose and its limitations
- I have given the mother/father/guardian an opportunity to ask questions about any of the above matters and raise any other concerns which I have answered as fully as possible. I am of the opinion that the mother/father/guardian understood the information provided.

Signature (Requesting Practitioner) ..... **Date** ..... ./..... ./..... **Contact Number**.....

Was an interpreter required? Yes/No If yes, was an interpreter present? Yes/No

Please complete and return via email to:
Healthy_Hearing@health.qld.gov.au

To contact Healthy Hearing: Phone 07 3310 6220

Healthy Hearing Criteria Met? No Yes - Healthy Hearing Billing HHP