

PATIENT SURNAME	GIVEN NAME(S)	SEX	DATE OF BIRTH	YOUR REFERENCE
PATIENT ADDRESS	POSTCODE	TEL (HOME)	TEL (BUS / MOBILE)	

TESTS REQUESTED

BODY REGION SEE KEY OVER PAGE	SPECIMEN SITE - FREE TEXT WRITE SPECIFIC SPECIMEN LOCATION (EG L CHEEK)	NEW LESION? ✓ IF YES NO PRIOR HISTO PERFORMED	PROVISIONAL DIAGNOSIS (PD) OR PAST BIOPSY RESULT SEE KEY OVER PAGE	EXCLUDE MELANOMA? ‡ ✓ IF TESTING TO EXCLUDE MELANOMA OR NMSC	EXCLUDE NMSC? †	CURRENT BIOPSY TYPE* SEE KEY OVER PAGE	CURRENT SURGICAL MANAGEMENT SEE KEY OVER PAGE	DERMOSCOPY ✓ IF YES
1								
2								

CLINICAL NOTES

RECORD ADDITIONAL LESION DATA ON REVERSE

EMERGENCY PHONE FAX BY TIME: _____
 PHONE/FAX No.: _____
 PRIVATE SCHEDULE MEDICARE
 VET AFFAIRS/WORK COMP No.: _____

DOCTOR'S SIGNATURE AND REQUEST DATE

X _____ / ____ / ____

If Rule 3 Exemption

HISTO	OTHER

COPY REPORTS TO:

REFERRING PRACTITIONER (PROVIDER NUMBER, NAME, ADDRESS)

SPECIMEN/S
CHECKED BY
PATIENT/WITNESS

HOSPITAL / WARD

Practitioner's Use Only (Reason for Patient unable to sign)

Self Determined

Hospital status of patient at specimen collection or date of service

	Yes	No
Private patient in a private hospital	<input type="checkbox"/>	<input type="checkbox"/>
Private patient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>
Hospital patient in a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient of a recognised hospital	<input type="checkbox"/>	<input type="checkbox"/>

MEDICARE ASSIGNMENT (Section 20A of the Health Insurance Act 1973)
 By this declaration I assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s). I declare that none of the services claimed in this form relate to an accident, injury or illness which has, or may result in the payment of compensation or damages.

PATIENT'S SIGNATURE AND DATE

X _____ / ____ / ____

COLLECTION	
LOCATION	INITIALS
C D N H DR	
DATE	TIME

- Please ensure both patient name and date of birth are complete prior to removing label.
- Remove label and attach to specimens.
- If more than three specimens, please record patient details directly on additional containers.

Surgical Audit

Please complete additional information on reverse side of this request form.

DATE	TIME	AM	SEX	PULL	DATE	TIME	AM	SEX	PULL	DATE	TIME	AM	SEX	PULL
COLLECTED		PM	M/F		COLLECTED		PM	M/F		COLLECTED		PM	M/F	
NAME:					NAME:					NAME:				
D.O.B.:					D.O.B.:					D.O.B.:				

PLEASE DO NOT USE LABELS ON GLASS SLIDES - BEND TO REMOVE LABEL

MEDICARE CARD NUMBER

SEX	DATE OF BIRTH	YOUR REFERENCE
	TEL (HOME)	TEL (BUS / MOBILE)

TESTS REQUESTED

PATIENT COPY

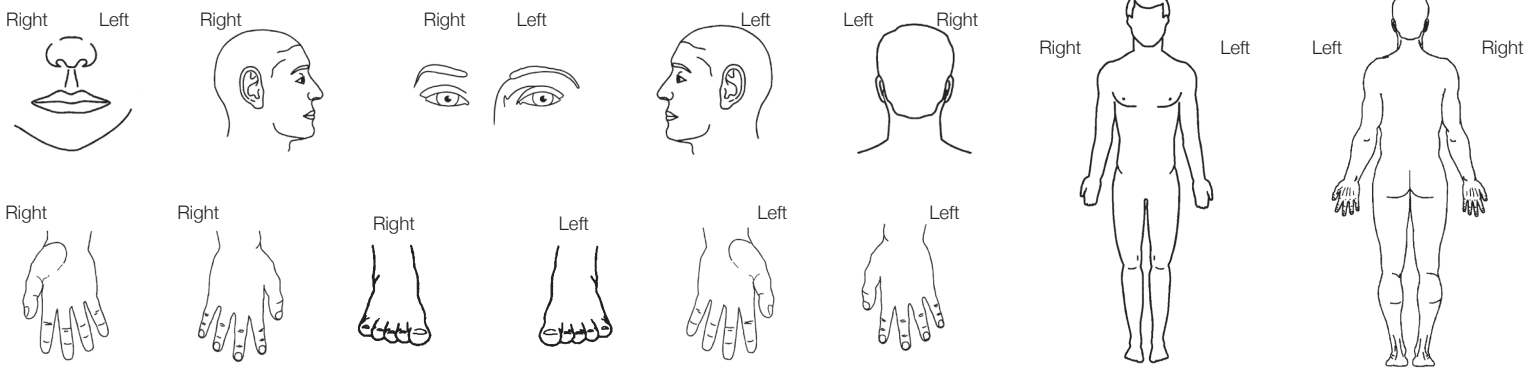
REFERRING DOCTOR (PROVIDER NUMBER, NAME, ADDRESS)

Surgical audit: General

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Number each specimen clearly and record details below

BODY REGION SEE KEY BELOW	SPECIMEN SITE - FREE TEXT WRITE SPECIFIC SPECIMEN LOCATION (E.G L CHEEK)	NEW LESION? ✓ IF YES NO PRIOR HISTO PERFORMED	PROVISIONAL DIAGNOSIS (PD) OR PAST BIOPSY RESULT SEE KEY	EXCLUDE MELANOMA?‡ ✓ IF TESTING TO EXCLUDE MELANOMA OR NMSC	EXCLUDE NMSC?†	CURRENT BIOPSY TYPE* SEE KEY	CURRENT SURGICAL MANAGEMENT SEE KEY	DERMOSCOPY ✓ if yes
3								
4								
5								
6								
7								
8								



BACKING CLEAR AREA FOR DIECUTTING

Key - Please note marking on diagrams cannot be used for surgical audit purposes. Please complete the grid above

Body region	Provisional diagnosis (PD) or past biopsy result	Current biopsy type *margins are not reported	Current surgical management (margins reported when applicable)
Abdomen	AK Actinic keratosis/solar keratosis	C Curettage	E Ellipse
Arm	BCC Basal cell carcinoma	Ex Excisional	F Flap
Back	B Cyst Benign cyst	I Incisional	SSG Graft: SSG
Buttock	DF Dermatofibroma	PS Punch sample	FTG Graft: FTG
Chest	IEC IEC/Bowen's disease	PR Punch removal	NC No closure
Ear	KA Keratoacanthoma	SS Shave sample	SxEx Shave/saucerisation
Eyelid	LPLK Lichen planus-like keratosis	SR Shave removal	CxCx Curettage and cautery
Finger	MCC Merkel cell carcinoma	O Other	O Other (inc MOHs)
Finger palmar	OB Other benign		
Foot	OM Other malignant		
Foot plantar	SCC Squamous cell carcinoma		
Forearm (elbow and below)	SebK Seborrhoeic keratosis		
Genitalia	SGH Sebaceous gland hyperplasia		
Hand	SK Solar keratosis		
Hand palmar	SL Solar lentigo		
Leg (knee and below)	HMF Hutchinson's melanotic freckle		
Lip	MMInv Melanoma: Invasive		
Neck	MMis Melanoma: In situ		
Nose	MMmet Melanoma: Metastasis		
Other face	BN Naevus: Blue		
Scalp	DN Naevus: Dysplastic		
Shoulder	N Naevus: Banal		
Thigh	SN Naevus: Spitz		
Toe			
Toe plantar			

Notes:

- Provisional diagnosis (PD):** required to include new lesions in the PD report.
- Exclude melanoma/NMSC:**
 - ‡ tick box if testing to exclude melanoma
 - † tick box if testing to exclude NMSC
 These lesions are included in the **Number Needed to Treat (NNT)** calculations on your report.
- Biopsy OR Surgical Management:** only enter one (if there is an entry in both, the Surgical Management will be used).
- MOHs:** record "MOHs" with specimen site (eg L cheek MOHs) - Current surgical management = O (other)