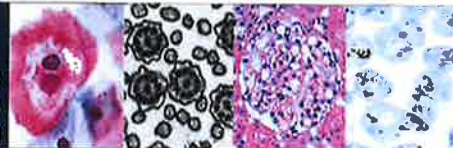


Second Opinion / Review Request Form



Tissue Pathology & Diagnostic Oncology, ICPMR Westmead
 Level 3, Locked Bag 9001, Westmead NSW 2145 Australia
 Tel: (61) 2 8890 6222 | Fax: (61) 2 9687 2330



Please send the completed request along with a copy of the original pathology report and slides to the address above. Incomplete forms will delay the processing of requests. Adequate patient, requestor and biller information is required.

A Medicare rebate is available for a second opinion, requested by a treating practitioner where both the treating practitioner and the original reporting pathologist agree that a second opinion is needed for diagnostic purposes and appropriate management.

Does this request fulfil the above requirements: **YES** NO If NO, a non MBS fee will apply. This will be billed to the debtor identified below

Name:	Provider Number:
Company:	
Address:	
Contact Number:	Email:
Facility:	Cost Code: Entity:

Patient Details (Illegible and incomplete details delay processing)

LOCATION/FACILITY: <input type="checkbox"/> Not currently inpatient	Your doctor has recommended that you use Pathology West. 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. Mandatory Information status of patient at specimen collection or date of service: <input type="checkbox"/> A private patient in a private hospital or approved day hospital facility <input type="checkbox"/> A private patient in a recognised hospital <input type="checkbox"/> A Medicare (public) patient in a Recognised hospital <input type="checkbox"/> An outpatient of a recognised hospital <input type="checkbox"/> An Overseas visitor <input type="checkbox"/> Specimen for research only <input type="checkbox"/> Veterinary <input type="checkbox"/> Privately referred outpatients	MEDICARE NUMBER (MANDATORY)
MRN:		
SURNAME:		
GIVEN NAME:		
ADDRESS:		
CITY: POST CODE:		
STATE: COUNTRY:		
DOB: SEX: M / F WARD/CLINIC:		* PATIENT SIGNATURE DATE MEDICARE ASSIGNMENT (Section 20A of the Health Insurance Act 1973). I offer to assign my right to benefits to the Approved Pathology Practitioner who will render the requested pathology services. Practitioner's Use Only (Reason patient unable to sign)

Requesting Doctor (Illegible and incomplete details delay processing)

SURNAME:	GIVEN NAME:
PROVIDER NUMBER:	COMPANY/FACILITY:
ADDRESS:	
PHONE:	FAX:
SIGNATURE:	DATE:
Requestor is: <input type="checkbox"/> Original Reporting Pathologist <input type="checkbox"/> Pathologist (other) <input type="checkbox"/> Clinician <input type="checkbox"/> Patient <input type="checkbox"/> Next of Kin <input type="checkbox"/> Other:	

Copy to Doctor (Illegible and incomplete details delay processing)

SURNAME:	GIVEN NAME:
ADDRESS:	
PHONE:	FAX:

Test Requested

<input checked="" type="checkbox"/> Second Opinion (MBS) (Treating Clinician & Reporting Pathologist agree second opinion is needed for management)	Lab Reference / Accession Number:
<input type="checkbox"/> Second Opinion (Non-MBS)	Material Sent: H&E x Specials x IHC x Blocks x Unstained x Blocks x Images x Discs x
<input type="checkbox"/> Review case for MDT presentation Meeting: Date of meeting:	If additional stains are likely, please send one block or 10 unstained sections on +ve charged slides (all blocks and slides will be returned).

Please direct this request to: If nominated pathologist is unavailable, the case will be referred to an appropriate pathologist in TP&DO.	Clinical Notes / Reason for Referral: Pdx of amyloidosis type: Organs involved: Monoclonal gammopathy findings (if present): kappa and lambda free light chains = paraprotein type and amount= REFERRAL For confirmation of amyloidosis. For typing with ATTR, kappa, lambda, AA stains
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