AUSTRALIAN Clinicalabs

INR R3X REQUEST FORM

BARCODE

ACC CODE

INR

Please present for testing between 10am - 12pm

Surname	Given Name	
Address		Mobile Number
Date of Birth	Sex ☐ Male ☐ Female	DVA Number / Referral Date / Medicare Number

CURRENT WARFARIN DOSE:

DAILY _____(MG)

ALTERNATING _____(MG)/_____(MG)

Mon___(MG) Tues___(MG) Wed___(MG) Thurs___(MG) Fri___(MG) Sat___(MG) Sun___(MG)

Coumadin (warfarin sodium)

Light Tan 1mg Lavender 2mg Green 5mg

Marevan (warfarin sodium)

Brown 1 mg Blue 3mg Pink 5mg

SINCE YOUR LAST TEST:

1INR	Have you missed any doses? If Yes what date/s	☐ YES	☐ NO
2INR	Have you started any new medication (includes prescribed, over the counter, herbal and vitamins)? List all new medications and dates started.	☐ YES	☐ NO
3INR	Are you on clexane (injections)?	☐ YES	☐ NO
4INR	Have you ceased any medications? List which and when?	☐ YES	☐ NO
5INR	Has your diet changed? How?	☐ YES	☐ NO
6INR	Have you had more than 2 standard drinks of alcohol in any one day?	☐ YES	☐ NO
7INR	Have you had any bleeding?	☐ YES	☐ NO
8INR	Have you had any bruising larger than 2 cm?	☐ YES	☐ NO
9INR	Have you attended an emergency department or been hospitalised?	☐ YES	☐ NO
10INR	Do you have any upcoming medical or dental procedures?	☐ YES	☐ NO
11INR	Have you been sick? Please specify	☐ YES	☐ NO
12INR	Collectors: was this a difficult bleed?	☐ YES	☐ NO

Please provide additional information including DATES to any questions answered "yes" here:

.....

.....

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 service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner. In the alternate, I authorise that APP to submit my unpaid account to Medicare so that Medicare can assess my claim and issue me a cheque payable to the APP for the Medicare Benefit.

I confirm that the information provided on this form by myself to Australian clinical labs is accurate. I understand that Australian Clinical Labs will not be responsible for any adverse medical outcome sustained by me as a consequence of providing Australian Clinical Labs with inaccurate information.

PATIENTS SIGNATURE .....

DATE .....

REQUESTING DOCTOR INFORMATION

DOCTOR SURNAME .....

DOCTOR GIVEN NAME(S) .....

.....

CLINC ADDRESS .....

.....

PROVIDER NUMBER .....

COPIES TO .....

.....

PERSON DRAWING BLOOD

I certify that the blood specimen(s) accompanying this request was drawn from the patient named above. I established the identity of this patient by direct inquiry and/or inspection of wrist band and immediately upon the blood being drawn I labelled the specimen(s)

COLLECTOR SIGNATURE .....

TIME OF COLLECTION .....

DATE .....

ACLMAR-REQ-NAT-0017.17 09/17 ACLZPAD0006