

PATIENT LAST NAME	GIVEN NAMES	SEX	DATE OF BIRTH	FILE No.
PATIENT ADDRESS		POSTCODE	TEL (HOME & MOBILE)	TEL (BUS)

TESTS REQUESTED

QML Collector – please collect:

Laboratory Urine Drug Screen

DS2

Supervision Level 3

Is patient:

Fasting

Non Fasting

PREPAYMENT REQUIRED AT TIME OF COLLECTION - \$66.00 (inclusive of GST).

Collector: Please call QML Data Entry (3121 4437) to process credit card payment.

RECEIPT NUMBER: _____

LAB INSTRUCTIONS: Ochsner MD Programme DS2 with extended report comment

STANDARD PRECAUTIONS PRIVATE & CONFIDENTIAL CUMULATIVE REPORT

URGENT PHONE FAX BY TIME:

PHONE/FAX No: _____

Bill Code: **CPP**

COMPANY DETAILS

Prepayment

COPY REPORTS TO: _____ REQUESTING DOCTOR, WORKPLACE HEALTH AND SAFETY OFFICER

For further information regarding this account, please contact QML Occupational Pathology Services on (07) 3121 4945.

X...../...../.....
PATIENT'S SIGNATURE AND DATE

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).
 Signature.....

L A S E	Collect Date	Coll. Time	Test Codes	Branch	Ref. No.	Lab. No.	Description & Containers	Collector
	Received Date	Rec. Time		B/C	Clinic			
				CPP				

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CLIENT COPY

REQUESTING DOCTOR, WORKPLACE HEALTH AND SAFETY OFFICER