Therapeutic Venesection Registration Form

INSTRUCTIONS

I hereby request therepeutic venesection for the below patient, who is under my care.

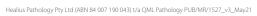
- I understand that the patient must meet the criteria for venesections.
- The patient has a medical condition for which venesection is indicated (haemochromatosis, polycythaemia, porphyria).
- I am aware that QML Pathology does not manage these patients and is not responsible if my patient does not attend for venesections. Regular patient review is the responsibility of the treating physician.
- I am aware that I am responsible for monitoring the patient and advising QML Pathology of any changes in the venesection schedule.
- I understand that ongoing confirmation is required from me.
- I am aware that my patients may, on request, be given the Hb and Iron result by QML Pathology staff as a guide to their progression towards the target level set by me.

REFERRING CLINICIAN DETAILS						
Name:				Pho	ne:	Fax:
Provider No.: Signa			Signatu	ure:		Date:
Please provide ALL requested information on your patient. We are unable to perform venesections on patients without this information. NOTE: A new referral is required each 12 months. With each new referral a cost of \$150 or \$75* (concession) will apply.						
PATIENT DET	AILS					
Patient Name:						Date of Birth:
Address:						
Home Phone:			Mobile Phone: Work Pho			one:
PATIENT MEDICAL DETAILS						
Condition requiring therapeutic venesection:						
Most recent Iron Studies (please attach results if not performed by QML Pathology):						
Most recent Full Blood Count (please attach results if not performed by QML Pathology):						
Other medical conditions:						
Recommended venesection frequency:						
□ Weekly □	2 Weekly	□Monthly	\Box 2 Monthly	□ 3 Monthly	Other (please specify)	
Further pathology testing required at time of Venesection						
□ FBC □	∃Hb	□ Ferritin	□ Iron Studies	E/LFT	Other (please specify)	
Target level for my patient: OR					-	
\Box HCT (suggested level HCT < 0.45) Note: A new referral is required each 12 months. Venesections are <u>not</u> a Rule 3 item.						

PLEASE HAND COMPLETED FORM TO YOUR PATIENT.

*Prices correct at time of printing and are subject to change without notice.







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