QML Pathology
Healius Pathology Pty Ltd (ABN 84 007 190 043) APA No. 000042 t/a QML Pathology.
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RCPA The Royal College of Pathologists of Australasia

NATA ACCREDITED FOR TECHNICAL COMPETENCE

Accredited for compliance with NPAAC Standards and ISO 15189
Accreditation Number: 2184

MEDICARE CARD NUMBER

SYNACTHEN® REQUEST

PATIENT DETAILS

Patient Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

REFERRING CLINICIAN DETAILS

Name: _____

Address: _____

Phone: _____ Fax: _____

Provider No.: _____ Signature: _____ Date: _____

TESTS REQUESTED

- Fasting
- Non Fasting
- Pregnant
- Horm Therapy
- LMP ___/___/___
- EDC ___/___/___

CLINICAL NOTES

☐ SELF DETERMINED ☐ STANDARD PRECAUTIONS ☐ PRIVATE & CONFIDENTIAL ☐ CUMULATIVE REPORT

URGENT ☐	PHONE ☐	FAX ☐	BY TIME:	PHONE/FAX No:
QML Fee ☐	S.F. ☐	B.B. or D.B. ☐		VET AFFAIRS No:

Was or will the patient be, at the time of the service or when the specimen is obtained: (✓ appropriate box)

	yes	no
a. a private patient in a private hospital or approved day hospital facility	☐	☐
b. a private patient in a recognised hospital	☐	☐
c. a public patient in a recognised hospital	☐	☐
d. an outpatient of a recognised hospital	☐	☐

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.

PATIENT'S SIGNATURE AND DATE

X ..... X ...../...../.....

Practitioner's Use Only ..... *(Reason patient cannot sign)*

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.....

LAB USE

Collect Date	Coll. Time	Test Codes	Branch	Ref. No.	Lab. No.	Description & Containers	Collector
Received Date	Rec. Time	Attachments: Yes / No (please circle) If yes, no. of pages:	B/C	Clinic			

ESSENTIAL PATIENT INFORMATION FOR INTRAMUSCULAR TETRACOSACTRIN (SYNACTHEN®):

An Intramuscular Tetracosactrin (Synacthen®) injection is used to test the body's ability to produce cortisol.

Cortisol is created in the adrenal glands and is an essential steroid hormone that maintains blood pressure, blood sugar, metabolism, and responds to infections.

Synacthen® is a man made hormone that can be used to test the function of the adrenal gland and is given as a single injection directly into the muscle.

The Intramuscular Tetracosactrin (Synacthen®) test takes one hour from the time of injection, so please allow at least one and a half hours to be in the unit. During this procedure three blood samples are taken; one before the dose of Syacthen® and the others 30 minutes and 60 minutes after the dose respectively.

This is a test only and not a treatment for poorly functioning adrenal glands.

Please ensure you have something to eat and drink (at least 600ml) before your appointment.
Please wear loose fitting clothing for your treatment. It is important that your sleeve can be pushed well above the elbow.
Be cautious when driving a vehicle or operating machinery after injection.

Please be aware some medications may affect the results of the Synacthen® test. These include:

- Some corticosteroid medicines, including cortisone and hydrocortisone.
- Spironolactone, a medicine usually used to treat high blood pressure and fluid retention.
- Oestrogens, including the birth control pill and hormone replacement therapy (HRT).

Follow your doctor's advice regarding dosing prior to the Synacthen® test.
Payment is required on the day of treatment. We accept credit cards (Mastercard & Visa) and eftpos only.

Synacthen® Injection Patient Consent Form

Informed Consent to Receive Intramuscular Tetracosactrin (Synacthen®)

The patient understands that the administration of Synacthen® comes with the following risks, included but not limited to:

- Anaphylactic reactions, which in rare cases may be potentially fatal
- Redness or pain at the injection site
- Skin Irritations such as rash, itching, hives or flushing at the injection site
- Headaches, light headiness, dizziness
- Nausea (feeling sick) or vomiting
- Difficulty breathing, including shortness of breath
- Swelling of the face, lips, tongue or other parts of the body
- Increased blood sugar level
- Minor reactions to Synacthen® may last up to 48 hours post injection.

Understanding these risks, patient gives authority for staff of QML Pathology to administer all necessary first aid and/or resuscitation measures, including alerting an ambulance and my Emergency Contact, in the unlikely event that an adverse or anaphylactic reaction occurs.

As Synacthen® is **not suitable** for patients in some conditions, patient declares that none of the below listed is applicable:

- Previous allergic reaction to ACTH and / or tetracosactrin, the active ingredient in Synacthen®
- Viral disease or recent vaccination with live virus
- Peptic ulcer
- Acute psychoses
- Cushing's syndrome
- Infections (unless antibiotics are being administered at the same time)
- Heart failure (refractory)
- Pregnancy and breast feeding
- Adrenocortical insufficiency
- Precaution in patients with asthma or other allergic conditions
- Precaution in patients with diabetes mellitus or moderate to severe hypertension

The patient, as stated below, has read and understood all information provided in this document.

The patient understands that this procedure is undertaken entirely at their own risk and is requesting medical intervention in the form of intramuscular Tetracosactrin injection.

The patient understands and consents to supply of Synacthen® along with upfront payment for service of $85.95* to QML Pathology.

Patient

Full Name: ..... DOB: .....

Address: .....

Signature: ..... Date: .....

Doctor performing Intramuscular Injection

Date: ..... Signature: .....

Attach Lab no. here

Office use only

*Prices correct at time of printing.

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