

SURNAME	GIVEN NAME	DATE OF BIRTH	SEX
ADDRESS	SUBURB	POSTCODE	
PHONE NUMBER	MEDICARE/REPAT NUMBER	PATIENTS: CODE / UR NUMBER	
<div>PATIENT STATUS AT TIME OF COLLECTION</div> <div><div><input type="checkbox"/> Public patient in a recognised hospital</div><div><input type="checkbox"/> Outpatient of a recognised hospital</div><div><input type="checkbox"/> Private patient in a recognised hospital</div><div><input type="checkbox"/> Private patient in a private hospital approved day hospital facility</div></div>			
CLINICAL NOTES		DOCTOR'S NAME	
TESTS REQUESTED		COPY TO	
<div>US + FNAB +/- Core Biopsy</div> <div><input type="checkbox"/> URGENT</div>			
		DOCTOR'S SIGNATURE	
		DATE	