



Requestor Code Creation Form for Labtests

Requestors Information (Please complete all relevant shaded areas using block letters)

Salutation	<input type="checkbox"/> Dr	<input type="checkbox"/> Mr	<input type="checkbox"/> Ms	<input type="checkbox"/> Mrs	<input type="checkbox"/> Prof	<input type="checkbox"/> Other
Job Title	<input type="checkbox"/> GP	<input type="checkbox"/> Midwife	<input type="checkbox"/> RMO	<input type="checkbox"/> NUR	<input type="checkbox"/> COM	<input type="checkbox"/> Other
Surname				First name		
Email Address						
After hours: Mobile	02	Other				

Role (select one)

<input type="checkbox"/> Specialist	<input type="checkbox"/> GP	<input type="checkbox"/> Locum	CPN(HPI) #	NZMC #:	<input type="checkbox"/> Alternative health professional
<input type="checkbox"/> Smear Taker only	Smear Taker ID:	<input type="checkbox"/> Staff Nurse (including smear taker)	NCNZ #:	Speciality:	

Practice Information (Please use block letters)

Company Name						
Practice Name				HPI Facility ID		
PHO				DHB region		
Main type of work	<input type="checkbox"/> General Practice	<input type="checkbox"/> Specialist Practice	Other:			
Phone			Fax*			
Healthlink address			General email			
Preferred results delivery (tick)	<input type="checkbox"/> Healthlink	<input type="checkbox"/> Fax	<input type="checkbox"/> Paper copy			
Practice Manager/ Main Contact Name			Practice Manager/ Main Contact Email			

*By providing a fax number on this form you are confirming that confidential patient information can be sent to this number. Labtests will fax urgent results.

Physical Communications (Please use block letters)

	Postal Address (NZ Post format)	For couriers (if different)
Street Address		
Suburb		
City		
Post code		
Courier pick and drop off instructions:		

I would like to receive electronic clinical information and updates from Labtests

I confirm that all information contained in this form is correct

Privacy Statement Labtests a division of Healthscope collects this information to facilitate the sending of laboratory results and related health information. Labtests will also share this information with other organisations within the health sector for clinical purposes.

Requested By: _____ Signature of Requestor: _____
Date of request: _____

Return completed form to email address: lta.practitioners@labtests.co.nz or Fax to 09 574 7284

If you have any queries call 09 574 7399

Office Use only	<input type="checkbox"/> Verified and Released By	Code Allocated: Date:	Run Allocated: Requester notified <input type="checkbox"/>
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