the children's hospital at Westmead
The Sydney children's Hospitals Network

Corner Hawkesbury Road
and Hainsworth Street
Locked Bag 4001
Westmead, Sydney,
NSW, Australia, 2145
schn.health.nsw.gov.au
ABN 53 188 579 090

Patient consent for non-rebatable Pathology test

Please print all details clearly

I _____ (Patient/Parent/Carer full name) understand that my/my child's medical practitioner has requested pathology testing that is not covered by Medicare Australia, the Department of Veterans' Affairs or a private health fund.

I understand that I will receive an invoice from The Sydney Children's Hospitals Network/The Children's Hospital at Westmead Pathology Department or another pathology service depending on the test(s) performed.

I agree to accept all responsibility for any out–of–pocket expenses for the test(s) as requested by my/my child's medical practitioner.

Affix addressograph or laboratory sticker here

Patient/Parent/Carer Signature: _____ Date: _____

Patient/Parent/Carer mobile number: _____

Pathology staff name (please print): _____ Signature: _____

The Children's Hospital at Westmead Pathology Department is to retain a signed and dated copy of this form, and the original is to be provided to the patient/parent/carer.

Western Sydney Genetics Program use only

☐ NSW Biochemical Genetics Test(s):
Cost(s):

☐ Sydney Genome Diagnostics Test(s):
Cost(s):

Patient Consent for Non-Rebateable Test Form - Version: 2.0. Index: DOC-OP-2240. Printed: 20-Sep-2019 09:41