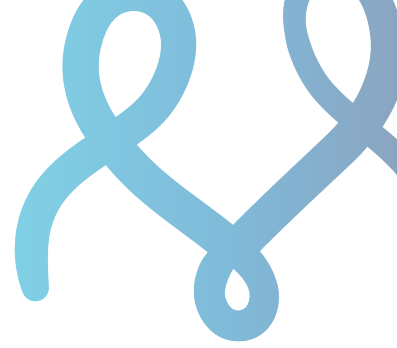


Payment authorisation



PATIENT DETAILS

LAST NAME:
GIVEN NAMES:
DOB:
UR/GF#:
VCGS LAB # (if known):

PARENTS/PARTNER/OTHER TO BE TESTED

LAST NAME: **1.** **2.**
GIVEN NAMES:
DOB:
UR/GF #:
VCGS LAB # (if known):

VCGS TEST

Requesting consultant:
Test requested:
Test fee:

SEND INVOICE TO: VCGS PATIENT OTHER

NAME AND ADDRESS:

PAYMENT AGREEMENT/AUTHORISATION

- VCGS OTHER HEALTH SERVICE
 PATIENT/GUARDIAN FULL PAYMENT

I agree to pay all associated costs as detailed above.

Name: Cost:

Signed: Date:

Phone/mobile:

This completed form must be submitted to the laboratory together with the pathology request form and specimen.