

Requestor Code Creation Form



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)	NCONZ #:	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. Northland Pathology 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 confirm that all information contained in this form is correct

Privacy Statement Northland Pathology, a division of Healthscope, collects this information to facilitate the sending of laboratory results and related health information. Northland Pathology 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: admin@norpath.co.nz

If you have any queries call 09 438 4243

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

Date Issued: 20/08/2020

Authorised by: HOD, Clinical Data Centre

NPL-DED-002

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