LifeLabs®

Contact: _____ **Fax:** _____

Department: _____ **Tel:** _____

Request for Patient Demographic Correction

www.LifeLabs.com

PHYSICIAN INFORMATION:		
To:	Fax Number:	Date: *dd/mm/yyyy*
REQUISITION ATTACHED: ☐ Yes ☐ No		
TOTAL NUMBER OF PAGES (INCLUDING FORM):		

REASON FOR COMMUNICATION:

A request for a change in patient demographics has been made to a previously reported report. In order to process this request and correct the report, a patient demographic verification including an ordering healthcare provider signature is required. Please fill in the below information to proceed with the request.

ORDERING HEALTHCARE PROVIDER RESPONSE:

	PREVIOUS INFORMATION	CURRENT AND CORRECT INFORMATION
PATIENT FIRST NAME		
PATIENT LAST NAME		
DATE OF BIRTH		
HEALTH CARD NUMBER		
GENDER		
OTHER INFORMATION		

I,_____, confirm that the above information for this patient is correct. I take full responsibility for the enclosed corrected patient demographics and approve the correction of the previously issued report.

Ordering Healthcare Provider (print) _____ Signature _____ Date