LifeLabs GENETICS™

1-844-363-4357 · Ask.Genetics@LifeLabs.com

CHANGE AUTHORIZATION FORM

Purpose: *This form is to be used to notify LifeLabs of any changes to the original requisition*

Instructions: *Please fill out the applicable corrected information below, patient name and date of birth (D.O.B.) are mandatory. Once the form is received, the appropriate changes will be made and an amended report will be issued if necessary.*

PATIENT: ______________________________ D.O.B (*MM/DD/YYYY*): __________

ACCESSION ID (if available): ____

TEST CHANGES:

- ☐ **Cancel Test – *Sample will be disposed of immediately upon receipt of a cancellation request.***
- ☐ **ADD Fetal Sex to Results**
- ☐ **REMOVE Fetal Sex from Results**

CORRECTION TO PATIENT DEMOGRAPHIC INFORMATION *(PROVIDE CORRECTED INFORMATION)*

- ☐ **First name** _________________________ **Last name** ___________________________
- ☐ **Date of Birth (MM/DD/YYYY)** : ______________________
- ☐ **Estimated Due Date** _________________
- ☐ **Gestational age at time of draw**:____**weeks** +____**days, on draw date (*MMDDYYYY*)** _______________
- ☐ **Weight**:_________________**lbs or kg (circle one)**
- ☐ **Draw Date**: ______________________
- ☐ **Other: (please clarify)** ____

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CORRECTION TO CLINIC INFORMATION:

- ☐ **Physician Name:** ____
- ☐ **Please send results to the following clinic:** ____
  Clinic Fax: __________________________ **Clinic Phone:** ______________________________
  Clinic Address: ____
- ☐ **Copy-to Physician Name:** ____
- ☐ **Please send an additional copy of the results to the following clinic:** _______________________
  Clinic Fax: __________________________ **Clinic Phone:** ______________________________
  Clinic Address: ____

CORRECTION TO BILLING INFORMATION:

- ☐ **Test is Funded: *MOHLTC Checklist (Ontario) or Authorization Code (B.C.) MUST BE ATTACHED TO THIS FORM***
- ☐ **Bill Patient (self-pay): *Payment Authorization Form MUST BE ATTACHED TO THIS FORM***

I authorize LifeLabs Genetics to make the change(s) marked above.

Healthcare Provider signature_______________________________________ **Date** ____________________

Healthcare Provider name (print)____________________________________

PLEASE FAX COMPLETED FORM TO 647-943-2804