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.* ***Please include only amended information requested.***

PATIENT: _____ D.O.B (*MMDDYYYY*): _____

ACCESSION ID (if available): _____

PATIENT DEMOGRAPHIC INFORMATION CORRECTION *(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) _____**

_____

CLINIC INFORMATION CORRECTION:

- ☐ **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: _____

BILLING INFORMATION CORRECTION:

- ☐ **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***

TEST CHANGES:

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

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