



Cancel Request for Electronic Outpatient Lab Order

Clinic submitting request:

Name of Clinic: _____
 Address: _____
 City, State and Zip code: _____
 Phone: _____

Name of person submitting request (First and Last): _____

Instructions for office: *To request fill out form completely. Please print legibly!*

1. Check the appropriate box and fill out all information.
 - Provider Requested
 - Duplicate Test(s)
 - Wrong test ordered
 - Pt could not produce/be drawn (will go to SCHS draw site)
 - Pt drawn at clinic (future order no longer needed)
 - Other: _____

2. Fax to Laboratory Support Services at 541-706-6365.

Patient label:
 Last, first name:
 Date of Birth:

TEST(s)	Date Ordered	Ordering provider	Department

Instructions for Lab Support Services:

1. Cancel electronic ordered
2. Enter comments
3. Place this form in designated