Fax / Print Letter

Reset Form Letter

LABORATORY - REQUEST FOR DIAGNOSIS FOLLOW UP

Provider / designee: Fill out this form completely, sign and return to Lab at secure fax# 541-706-7746.
If you have questions call the laboratory Support Services Supervisor at 541-706-6387.

This is to support documentation for a change or correction requested by a provider, it is not an order.

Provider requests:

☐ Additional diagnosis, please rebill. _____
☐ Correction of diagnosis,_____
☐ Remove diagnosis,_____ add, _____
☐ Other, _____

Office providing information: _____

- **Provider/designee signature: _____**
- Full name of person requesting change: _____; and by initialing this box

you attest that the diagnosis change is documented in Office patient chart _____ (Initials).

Patient (Last, First, M):_____

Date of Birth: _____ **Date of Service:** _____

List the test involved in this change (this is not an order):

COMMENTS:

St. Charles Laboratory Use only:

Date and Time info provided: _____

Account Number: _____

Lab Support Service initials: _____

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This document is scanned into patient chart as transcribed order.