



DEMOGRAPHIC CHANGE REQUEST FORM

Facility Name: _____ Facility Phone Number: _____

Patient Name: _____

Test Requested: _____ Date Requested: _____

Please indicate the requested change(s) in the table below by marking the appropriate box, listing the original information on the requisition and the corrected information

X	Change Requested	Original Information	Corrected Information
	Patient Name		
	Gender		
	Body Site		
	Collection Date		
	Date of Birth		
	Suspected Diagnosis		
	Medical Record #		
	Ordering Facility		
	Ordering Physician		
	Level of Service		
	Specimen ID #		
	Specimen Type		
	Other		

Please make the requested changes as instructed above.

Requested by:

Signature

Print Name

Title

Date

CMDX Use Only

Who made the Changes:

Signature

Print Name

Title

Date

Once the signed request has been received for globals, an amended report will be generated, signed, and faxed. For tech only, changes will be made and the case will move back onto the physician worksheet. If you have any questions or need additional information, please contact our client services department at (800) 710-0624

Please fax this completed form back to Client Services @ (949) 753-4725

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