BIOTECH CLINICAL LABORATORIES

REJECTION AUTHORIZATION FORM

1) **CORRECTION REQUEST TYPE *(CHECK ONE)*:**

☐ TEST REQUISITION & SPECIMEN DO NOT MATCH ☐ UNLABEL SPECIMEN ☐ OTHER

2) **REQUEST DATE:** _____

3) **NAME OF PERSON THAT DREW/COLLECTED SPECIMEN(S) FROM PATIENT:** _____

4) **PATIENT INFORMATION SUBMITTED ON ORDER/REQUISITION:**

   a. PATIENT'S NAME: _____

   b. PATIENT'S D.O.B.: _____

   c. COLLECTION DATE: _____

   d. ACCESSION NUMBER: _____

   e. NAME ON SPECIMEN(S): _____

   f. SPECIMEN TYPE(S): _____

5) **CORRECT MISSING INFORMATION:**

   a. PATIENT'S NAME: _____

   b. PATIENT'S D.O.B.: _____

6) **PHYSICIAN'S AUTHORIZATION:**

   a. PHYSICIAN'S NAME: _____

   b. PHYSICIAN'S SIGNATURE _____ DATE: _____

IMMEDIATELY FAX COMPLETED FORM ATTN BRITTANY/KRISSY AT (248) 912-1730 OR (248) 348-2008