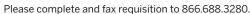
Test Cancelation Requisition



Consult



. 10000 00111p1010 01110 101110 101110 101		
PATIENT INFORMATION		
Patient Name		
Inform Diagnostics Accession No.		Date of Birth / /
CLIENT INFORMATION		
Client		
Phone	Fax	
Requested By	I	
By signing this requisition, I am authorizing the indicated test(s) to be can	eled by Inform Diagnostics. Cancelation mus	st be signed by authorizing clinician (or designee).
Authorized Signature		
REQUESTED TEST(S) TO BE CANCELED		
1		
2		
3		
FOR INTERNAL USE		
For Internal Routing Only		Date
Received		
To Lab		
To Path		