Test Cancelation Requisition

Please complete and fax requisition to 866.688.3280.

PATIENT INFORMATION

Patient Name	
Inform Diagnostics Accession No.	Date of Birth / /

CLIENT INFORMATION

Client	
Phone	Fax
Requested By	

By signing this requisition, I am authorizing the indicated test(s) to be canceled by Inform Diagnostics. Cancelation must 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	
Consult	

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