Test Revision Form

120 N. Pine St, Suite 152
Spokane, WA 99202
Phone: 844-255-3532
Fax: 509-232-5779
Email: info@allelediagnostics.com

Allele Diagnostics understands that there are instances when ordered tests need to be changed, added, or cancelled and can accommodate these requests with the completion of this authorization form. If adding a test is desired, the healthcare provider can contact our laboratory at 844-255-3532 to discuss the availability of the specimen(s) for additional testing. If a test is cancelled for any reason, Allele Diagnostics requests this form be completed and sent back. Please send the completed form via fax at 509-232-5779 or via email at info@allelediagnostics.com.

Change of Ordered Test

Patient full name _____
Patient date of birth _____ MRN _____
Test ordered _____
Change test to _____

Add a Test to an Order

Patient full name _____
Patient date of birth _____ MRN _____
Additional test to order _____

Cancellation of a Test

Patient full name _____
Patient date of birth _____ MRN _____
Test to cancel _____
Reason for cancellation _____
☐ Please issue a cancellation report for this test. (If this checkbox is not marked, no report will be issued.)

Authorized Signature for Test Revision

Healthcare provider name _____
Institution / Practice _____
Telephone _____ Fax: _____
Email _____

Authorized healthcare provider: As an authorized healthcare provider, I request and authorize Allele Diagnostics to revise the test(s) listed above. By signing below, I verify that I am an authorized healthcare provider and have obtained consent from the patient(s) and/or legal guardian(s) for the test(s) ordered.

Signature _____ Date _____
Signature of Authorized Healthcare Provider