Spectrum Health Regional Laboratory
Pathology and Laboratory Medicine
35 Michigan Street NE
Grand Rapids, MI 49503
Phone: 616-267-2660
Fax: 616-267-2661

REQUEST FOR CORRECTION

Written notification from the physician is required to change information in a pathology report.

On ___/___/___ our office/client sent specimen(s) and/or requisition form(s) to Spectrum Health Regional Laboratory labeled as follows:

Originally submitted Patient Name:
Originally submitted Date of Birth:
Originally submitted Specimen Designation:
Originally submitted Procedure:
Originally documented Collection Date and Time: _____/_____/_____ _____:____ ☐ AM / ☐ PM

**The specimen and/or requisition were labeled incorrectly.
Please change to the following:

Correct Specimen Designation:
Correct Procedure:_____
Correct Collection Date and Time: _____/_____/_____ _____:_____ ☐ AM / ☐ PM

**It is SH policy that any precious specimen patient identifier issues require the collector to come on site to make the correction. It is against SH policy to make patient identifier corrections to specimens considered non precious. Non precious specimens with incorrect identifiers will be discarded and will require recollection.

Physician Signature: _____ Date: ___/___/___

Physician Name (printed) _____