THE University of Vermont MEDICAL CENTER

MRN

Name

DOB

Amending Diagnosis Information

For Outpatient Lab Services Only

Date of Change Request: _____

Patient's Full Name: _____ Date of Birth: _____

Medical Record #: _____ Date of Service: _____

Please indicate what needs to be corrected:

☐ **Add diagnosis** _____

☐ **Remove diagnosis** _____

☐ **Change Order of diagnoses** _____

Reason for amendment:

You are responsible for ensuring that the accurate diagnosis is included in the patient's medical record.

Physician authorizing this change:

Physician's Name (print): _____ Physician's Location: _____

Physician's Signature: _____

Return form to:

Fax form to: 802-847-4179 **or** E-mail to: Registrationlab@vtmednet.org

Internal use only:

Person receiving change request: _____ Date change made in patient's billing record: _____

Note: This form must be scanned to the patient's medical record.