CHRISTUS SANTA ROSA Health System

	CSRS-GFM-10
PRIMARY DEPARTMENT: Laboratory – General	Event Date/Time: _____

STATEMENT OF RESPONSIBILITY FOR PATIENT IDENTIFICATION

I verify that the: CATH URINE CSF BODY FLUID OTHER: _____

Specimen originally mislabeled as _____ (PATIENT)

Collected on _____ (DATE) _____ (TIME), actually belongs to _____ (PATIENT).

I acknowledge that I take full responsibility for the identification of the above said specimen(s).

_____ _____

Nurse or Physician signature Date

_____ _____

Nurse or Physician (PRINT) Nursing Unit

***THIS FORM MAY ONLY BE USED AFTER COORDINATION WITH CHARGE NURSE OR PHYSICIAN WITH THE ACTING LABORATORY SUPERVISOR/CHARGE TECH.

LAB REPRESENTATIVE: _____ DATE _____

COMMENTS:

QA REVIEW COMMENTS:

RISK MANAGEMENT REPORT # _____

REVIEWED BY: _____ DATE _____