NewYork-Presbyterian

IRREPLACEABLE SPECIMEN ATTESTATION FORM

This form cannot be used for Blood Bank specimens.

SECTION 1: To be completed by the health care professional who collected the specimen (Specimen Collector)

NOTE: When a specimen is not positively identified by the health care professional who collected the specimen, results will not be released.

CORRECT PATIENT INFORMATION		INCORRECT PATIENT INFORMATION (*if applicable*)	
Name:		**Name:**	
MRN:	**DOB:**	**MRN:**	**DOB:**

CORRECT SPECIMEN INFORMATION	INCORRECT SPECIMEN INFORMATION (*if applicable*)
Collection Date: **Time (HH:MM):** **AM / PM**	**Collection Date:** **Time (HH:MM):** **AM / PM**
Accession Number(s):	**Accession Number(s):**

SPECIMEN TYPE (*check all that apply*):

- ☐ Autopsy
- ☐ Blood
- ☐ Bone marrow
- ☐ Cerebrospinal fluid (CSF)
- ☐ Culture (*specify*): _____
- ☐ Foreign body
- ☐ Outside blocks/slides
- ☐ Stone samples
- ☐ Tissue
- ☐ Urine
- ☐ Other specimens (*specify*): _____

Body site: _____

UNLABELED OR MISLABELED SPECIMENS The missing or incorrect information provided with the original specimen was (*check all that apply*):	SPECIMEN ACCEPTABILITY ISSUES (NON-LABELING) The reason(s) the specimen failed to meet acceptability criteria (*check all that apply*):
☐ Patient's name ☐ Patient's date of birth ☐ Patient's MRN ☐ Specimen collection date ☐ Specimen collection time ☐ Specimen source (anatomic site) ☐ Other (*describe below*)	☐ Specimen received beyond acceptable stability ☐ Specimen received without test orders due to incorrect completion of specimen collection workflow in Epic ☐ Specimen collected in the incorrect container or tube ☐ Incorrect media used (formalin, saline, etc.) ☐ Insufficient sample ☐ Hemolyzed sample ☐ Other (*describe below*)

Additional details describing the improper submission:

Below is a duplicate of the correct label(s) placed over the original specimen label(s) by the health care professional (*if applicable*):

Affix correct specimen label(s) here (if applicable).

Continue to Section 2

Abbreviations: DOB = date of birth, MRN = medical record number

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SECTION 2: Required signatures by Specimen Collector and Ordering Provider

I, _____,
(*Print Name and Title*)
the person responsible for the collection of the specimen (Specimen Collector), acknowledge that a specimen submission error occurred that has now been corrected (*check all that apply*):

☐ **Unlabeled/mislabeled specimen**
☐ **Failed acceptability criteria for testing**

I attest to the accuracy of the information in Section 1.

Specimen Collector's Signature: _____ **CWID:** _____

Date: _____ **Time (HH:MM):** _____ **AM / PM**

Phone Number: _____ **NYP Lab Witness (*if applicable*):** _____

NOTE: The Ordering Provider must be informed of the reason for the request to process the sample by the Specimen Collector, and agree to processing and resulting by signing below:

Ordering Provider attests to the validity of specimen information (above):
I confirm obtaining a new specimen(s) would have a negative impact on the condition of the patient, may yield significantly different diagnostic information and/or is not possible to obtain at this time.
I understand the following statement will be added to the patient's report of laboratory findings as per New York State Department of Health (NYSDOH) and College of American Pathologists (CAP) requirements (NYSDOH Clinical Laboratory Standards REP S2 and SP S4 and CAP GEN.41096): **"The specimen did not meet standard laboratory acceptability criteria; however, following review and documented authorization by the ordering physician, it was processed and resulted in accordance with regulatory requirements. Results should be interpreted with caution."**

Ordering Provider (*Print Name*): _____

Ordering Provider's Signature: _____

Date: _____ **Time (HH:MM):** _____ **AM / PM**

SECTION 3: To be completed by the Laboratory

Laboratory Personnel Reviewing This Form:

Print Name: _____ **CWID:** _____

Campus: _____ **Laboratory Name/Section:** _____

Date reviewed: _____ **KEEPSAFE number:** _____

Comments: _____

Laboratory Medical Director/Designee Final Review:

Before the test result is reported, laboratory personnel must submit this form to the Laboratory Medical Director or their designee for approval.

Print Name: _____

Signature: _____ **Date:** _____

This form is filed per local laboratory Standard Operating Procedures and retained in accordance with record retention requirements.