Request to CANCEL Test(s)

St. John's Medical Center Clinical Lab

Please fax completed form to (307)739-7323

If test is already in progress when cancellation request received, physician office may be held responsible for test charges.

Patient Name:

Date of Birth:

Original date of testing:

Test(s) to be canceled:

Ordering Physician Name:

Signature:

Date:

Internal use only:

Cancellation request scanned to patient registration orders (Date/by): _____

Completed by: Date: Time: