



## **Request to CANCEL Laboratory Test(s)**

**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: