PACIFIC DIAGNOSTIC LABORATORIES
CLINICAL LABORATORY LIABILITY RELEASE

TELEPHONE: 805.879.8100 FAX: 805.879.8169

SUBOPTIMAL/UNACCEPTABLE SPECIMEN: TRANSFER OF RESPONSIBILITY

PATIENT IDENTIFICATION DISCREPANCY

SPECIMEN	**REQUISITION**
NAME: _____	NAME: _____
DOB _____ MR# _____	DOB _____ MR# _____
ORDERING PHYS: _____	ORDERING PHYS: _____
SPECIMEN TYPE:	SPECIMEN TYPE:

TEST(S) REQUESTED: _____

PROBLEM

DATE _____ TIME _____ REPORTED BY _____ SUPV _____

- ☐ NO LABEL ON SPECIMEN
- ☐ LABEL AND REQUISTION NOT MATCHED
- ☐ INCOMPLETE INFORMATION

COMMENTS:_____

(continue on reverse, if necessary)

UNRESOLVED (SPECIMEN NOT PROCESSED)

PERSON NOTIFIED _____
(MD, RN, or other responsible person)

☐ STAFF DECLINED RESPONSIBILTY _____
(your name)

INSTRUCTIONS FOR REQUESTS: HAVE PHYSICIAN OR RESPONSIBLE ASSOCIATE FILL IN STARRED (***) LINES AND FAX BACK TO 805.879.8169

FAX MUST RECEIVED BY _____ (2 HOURS) AND SPECIMEN WILL BE PROCESSED ONLY BY DIRECT REQUEST OF PHYSICIAN. CLINICAL LABORATORY TELEPHONE: 805.879.8100

***PATIENT NAME _____ DATE OF BIRTH _____ DATE _____

***THIS SPECIMEN WAS OBTAINED FROM _____ TIME _____
(Source)

I AM ASSUMING FULL RESPONSIBILITY FOR PROPER IDENTIFICATION OF THIS SPECIMEN.

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PRINT PHYSICIAN'S OR RESPONSIBLE ASSOCIATE'S NAME

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PHYSICIAN'S SIGNATURE OR RESPONSIBLE ASSOCIATE'S SIGNATURE