**This form is only to be used for identification correction for Point-of-Care testing.**

**\*\*DO NOT SIGN IF YOU SUSPECT THE CORRECTED PATIENT I.D. IS INCORRECT\*\***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Corrected Patient I.D.** | |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Patient Name: |  |  | Location: |  |  |
|  | (Required entry) | |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Medical Record No.: |  |  | Financial No.: |  |  |
|  | (Required entry) | |  | (Required entry) |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Testing Date: |  |  | Testing Time: |  |  |
|  |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| I, |  |  |  | , confirm that the above |
|  | (Print Name) |  | (Signature-Required Entry) |  |
|  | | | | |
| information is correct and accept responsibility for the Point-of-Care testing performed. | | | | |
|  | | | | |
| **Comments:** | | | | |
|  | | | | |
|  | | | | |

**Identification error is due to one of the following reasons (**Selection required for documentation purpose**):**

|  |  |  |
| --- | --- | --- |
|  | Misidentification |  |
|  |  |  |
|  | I.D. Error |  |
|  |  |  |
|  | Pre-Admit | |
|  |  | |
|  | Downtime | |
|  |  |  |
|  | Other – Describe: |  |
|  |  |  |
|  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| Lab Use Only: | | |  |  |  |  |
|  |  |  |  |  |  |  |
| Date: |  | Lab Staff: |  |  |  |  |
|  |  |  | (Print Name) |  | (Signature) |  |
|  |  |  |  |  |  |  |