

# PATIENT MERGE FORM

Fax: 612-863-4114

<b>Lab staff: Please fill in ALL the information below.</b>	
Date:	Time:
Patient name:	DOB:
CORRECT Medical Record Number:	INCORRECT Medical Record Number:
<p>How verified:</p> <p> <b>R</b>    <input type="checkbox"/> Per Patient/Family    <input type="checkbox"/> Per RN/MD    <input type="checkbox"/> Per Clinic    <input type="checkbox"/> Per Epic    <input type="checkbox"/> Other  <b>E</b>  <b>Q</b>    Contact Person: _____  <b>U</b>  <b>I</b>    Notes:  <b>R</b>  <b>E</b>  <b>D</b> </p> <p>Verified by:    A # : _____    Initial: _____    Date: _____</p>	

≧ Staff requesting merge are responsible for verification ≦

<p><b>For use by LIS Staff:</b></p> <p>Verify:                      Patient name, DOB, and all PID information</p>	<p>Initials:</p>  <p>Date:</p>
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