# Bureau of Public Health Laboratories
# Demographic Correction Request Form

Please fill in as much information as possible for each section. This information is crucial to performing the corrections.
Name and birth date must be provided, along with any proof of change. Form must be legible.
If DOH Employee, the completed form may be emailed to **DLBOLMIS@flhealth.gov**, otherwise, fax to (904) 791-1567.

IN REFERENCE TO REQUISITION NUMBER(S): Enter requisition number, order number, lab specimen number or lab report number here. It's good to note which number you are using on this line.

## PATIENT INFORMATION

| **CORRECT**: ENTER THE GOOD INFO IN THIS COLUMN | | **INCORRECT**: ENTER WHAT WE ARE REPLACING (THE WRONG INFO) IN THIS COLUMN | |
|---|---|---|---|
| Last Name: | | Last Name: | |
| First Name: | | First Name: | |
| Birthdate: | | Birthdate: | |
| SSN: | | SSN: | |
| Address: | | Address: | |
| | | | |
| Phone: | | Phone: | |
| Gender: | | Gender: | |
| Race: | | Race: | |
| Ethnicity: | | Ethnicity: | |
| Other (specify): | | Other (specify): | |

## SPECIMEN INFORMATION

| **CORRECT**: | | **INCORRECT**: | |
|---|---|---|---|
| Collection Date: | | Collection Date: | |
| Date Received: | | Date Received: | |
| Specimen Source: | | Specimen Source: | |
| Other (specify): | | Other (specify): | |

INFORMATION PROVIDED BY:

Source: Good to have but optional, enter where you found the correct info, i.e. driver's license, medical record, typo, clerical error, etc.

Provider's Name: Enter your name here

Provider's Title: Enter your title here Phone: Enter your number here

Provider's Signature: Sign here Date: Today's date here

**For Internal Use Only:** Do Not Use.
To be completed by person making the changes in the Lab System.

Form Completed By: _____ Date: _____
Print Name

Signature: _____ Phone: _____

Revised: 10/12/2017 jgs