PETROGLYPH
PATHOLOGY SERVICES

AMENDED REPORT REQUEST

Requestor's Name _____ Date of Request _____

Requestor's Phone Number _____

Accession number of report to be corrected _____

Patient's Name _____

Details to be corrected _____

_____

_____

_____

Reason for correction _____

_____

_____

_____

Request Approved by _____
Printed Name of Submitting Physician

_____
Signature of Submitting Physician

Petroglyph Pathology will correct patient reports when a completed form is received. Incomplete forms will not result in corrected reports.

Fax completed form to 505.924.0210