CHI Franciscan Health

Our best care. Your best health.℠

FORM

SPECIMEN ACCEPTANCE AUTHORIZATION FORM

☒ **St. Joseph Medical Center, Tacoma, WA**
☒ **St. Francis Hospital, Federal Way, WA**
☒ **St. Clare Hospital Lakewood, WA**
☒ **St. Anthony Hospital Gig Harbor, WA**
☒ **St. Elizabeth Hospital Enumclaw, WA**
☒ **Highline Medical Center Burien, WA**
☒ **Harrison Medical Center, Bremerton, WA**
☒ **Harrison Medical Center, Silverdale, WA**
☒ **PSC**

Please provide the following patient information. All information must be provided.

Last Name	
First Name	
Medical Record Number	
Date of Birth	
Type of Specimen Submitted	
Name of Authorizing Provider or Pathologist	
Reason for Acceptance □ Irretrievable □ Other, specify	

□ Verbal Authorization, Read Back Completed by Tech Code _____________ on __________________.

Route to Client Services for final provider authorization.

Authorizing Provider Signature	

Unauthorized use or copying of this document is prohibited by FHS.