Merge Patient Request Form

SUBURBAN HEMATOLOGY-ONCOLOGY ASSOCIATES
AFFILIATED WITH NORTHSIDE HOSPITAL CANCER INSTITUTE

Please fill out as much information as possible for each section.

Correct Patient Informtion
(the record we are going to keep)

Name:_____

Medical Record Number: _____

Birthdate:_____

Address:_____

_____

Patient Sex:_____

Incorrect Patient Information
(record to be merged)

Name:_____

Medical Record Number: _____

Birthdate:_____

Address:_____

_____

Patient Sex:_____

Where did you discover the duplicate?

Centricity	☐
G4	☐
Onco EMR	☐

Your Name: _____ Date:_____

Manager Name:_____

MANAGER ONLY BELOW

Patient has been identified as having duplicate records and was merged on date:_____

These patients do not need to be merged. Reason:_____

Manager Signature:_____ Date:_____