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HOUSE CALL REQUEST

THIS FORM MUST BE COMPLETED IN FULL



PLEASE SCAN
TO SEND
THE REQUEST



PHYSICIAN'S INFORMATION

ACCOUNT#
NAME
NPI#
ADDRESS
CITY / STATE / ZIP
PHONE
FAX

PATIENT'S INFORMATION

PATIENT LAST NAME		FIRST NAME		AGE
GENDER	<input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH (M/D/Y)	PHONE	
ADDRESS				APT:#
CITY		STATE	ZIP	
INSURANCE		INSURANCE ID#		

STANDING ORDER:

2 x WEEK
 Q1 WEEK
 Q2 WEEKS
 Q1 MONTH
 Q2 MONTHS
 Q3 MONTHS
 Q4 MONTHS

REQUESTED DATE OF SERVICE _____

FASTING STAT

TESTS REQUESTED

H801 <input type="checkbox"/> PT+INR	BL
H802 <input type="checkbox"/> PTT	BL
H801 <input type="checkbox"/> CBC WITH DIFFERENTIAL & PLATELETS	LV
C301 <input type="checkbox"/> BMP (Gluc, Na, K, Cl, CO2, BUN, Cr, Ca, Creat)	SST
C302 <input type="checkbox"/> CMP (Gluc, Na, K, Cl, CO2, BUN, Cr, Ca, Creat, Tot. Prot., Alb, ALP, Tot. Billi.)	SST
C304 <input type="checkbox"/> LIPID PANEL (CHOL, HDL, LDLc, TRIG, vLDLc)	SST
C303 <input type="checkbox"/> HEPATIC FUNCTION PANEL (ALB, Tot. prot., Tot. Billi., ALP, AST, ALT)	SST
C327 <input type="checkbox"/> PHOSPHORUS	SST
C328 <input type="checkbox"/> MAGNESIUM	SST
C326 <input type="checkbox"/> URIC ACID	SST
I901 <input type="checkbox"/> THYROID PANEL	SST
C325 <input type="checkbox"/> HEMOGLOBIN A1C	LV
C304 <input type="checkbox"/> IRON DEFICIENCY PROFILE (IRON+TIBC+UIBC+SAT%)	GY
I925 <input type="checkbox"/> FOLATE	SST

I926 <input type="checkbox"/> VITAMIN B12	SST
I927 <input type="checkbox"/> FERRITIN	SST
I928 <input type="checkbox"/> TSH	SST
I929 <input type="checkbox"/> T4	SST
I930 <input type="checkbox"/> T4, FREE	SST
I931 <input type="checkbox"/> PSA, TOTAL	SST
I932 <input type="checkbox"/> CRP	SST
I933 <input type="checkbox"/> VITAMIN D (25 HYDROXY)	SST
C329 <input type="checkbox"/> SED RATE (ESR)	LV
IS04 <input type="checkbox"/> RHEUMATOID FACTOR (RF)	SST
IS35 <input type="checkbox"/> URINALYSIS, COMPLETE	UR
IS05 <input type="checkbox"/> URINE CULTURE & SENSITIVITIES	UR
IS12 <input type="checkbox"/> MICROALBUMIN, URINE	UR
T1060 <input type="checkbox"/> Covid-19, SARS-COV-2 PCR, Molecular Detection	SW

ICD-10 CODES

COMMENTS: _____

By signing below, the physician requesting a home visit by a laboratory phlebotomist is certifying that the patient is homebound (as defined by Medicare) and that both the home visit and the lab tests that are being ordered are medically necessary.

PHYSICIAN'S SIGNATURE _____

DATE _____