AMEDIX LABORATORY

Tel: 1-888-826-3349
Fax: 1-888-826-3349
amedix@amedixlaboratory.com

HOUSE CALL REQUEST

THIS FORM MUST BE COMPLETED IN FULL

PLEASE SCAN TO SEND THE REQUEST

PRINT FORM

PHYSICIAN'S INFORMATION

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

PATIENT'S INFORMATION

PATIENT LAST NAME	FIRST NAME	AGE
GENDER ☐ M ☐ 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	PT+INR	BL	I926	VITAMIN B12	SST
H802	PTT	BL	I927	FERRITIN	SST
H801	CBC WITH DIFFERENTIAL &PLATELETS	LV	I928	TSH	SST
C301	BMP (Gluc,Na,K,Cl,CO2, BUN, Cr, Ca, Creat)	SST	I929	T4	SST
C302	CMP (Gluc,Na,K,Cl,CO2, BUN, Cr, Ca, Creat, Tot. Prot., Alb,ALP,Tot. Billi.)	SST	I930	T4, FREE	SST
C304	LIPID PANEL (CHOL, HDL, LDLc, TRIG, vLDLc)	SST	I931	PSA, TOTAL	SST
C303	HEPATIC FUNCTION PANEL (ALB, Tot.prot., Tot. Billi., ALP, AST, ALT)	SST	I932	CRP	SST
C327	PHOSPHORUS	SST	I933	VITAMIN D (25 HYDROXY)	SST
C328	MAGNESIUM	SST	C329	SED RATE (ESR)	LV
C326	URIC ACID	SST	IS04	RHEUMATOID FACTOR (RF)	SST
I901	THYROID PANEL	SST	IS35	URINALYSIS, COMPLETE	UR
C325	HEMOGLOBIN A1C	LV	IS05	URINE CULTURE & SENSITIVITIES	UR
C304	IRON DEFICIENCY PROFILE (IRON+TIBC+UIBC+SAT%)	GY	IS12	MICROALBUMIN, URINE	UR
I925	FOLATE	SST	T1060	**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.

CLEAR FORM

EMAIL FORM

PHYSICIAN'S SIGNATURE _____ DATE _____