



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

036	<input type="checkbox"/> PT+INR	BL
037	<input type="checkbox"/> PTT	BL
20	<input type="checkbox"/> CBC WITH DIFFERENTIAL & PLATELETS	LV
1120	<input type="checkbox"/> BM P (Gluc,Na,K,Cl,CO2, BUN, Cr, Ca, Creat)	SST
1130	<input type="checkbox"/> CM P (Gluc,Na,K,Cl,CO2, BUN, Cr, Ca, Creat, Tot. Prot., Alb,ALP,Tot. Billi.)	SST
1150	<input type="checkbox"/> LIPID PANEL (CHOL, HDL, LDLc, TRIG, vLDLc)	SST
1140	<input type="checkbox"/> HEPATIC FUNCTION PANEL (ALB, Tot.prot., Tot. Billi., ALP, AST, ALT)	SST
127	<input type="checkbox"/> PHOSPHORUS	SST
125	<input type="checkbox"/> MAGNESIUM	SST
137	<input type="checkbox"/> URIC ACID	SST
3075	<input type="checkbox"/> THYROID PANEL	SST
119	<input type="checkbox"/> HEMOGLOBIN A1C	LV
850	<input type="checkbox"/> IRON DEFICIENCY PROFILE (IRON+TIBC+UIBC+SAT%)	GY
163	<input type="checkbox"/> FOLATE	SST

162	<input type="checkbox"/> VITAMIN B12	SST
115	<input type="checkbox"/> FERRITIN	SST
146	<input type="checkbox"/> TSH	SST
144	<input type="checkbox"/> T4	SST
252	<input type="checkbox"/> T4, FREE	SST
196	<input type="checkbox"/> PSA, TOTAL	SST
300	<input type="checkbox"/> CRP	SST
160	<input type="checkbox"/> VITAMIN D (25 HYDROXY)	SST
246	<input type="checkbox"/> SED RATE (ESR)	LV
304	<input type="checkbox"/> RHEUMATOID FACTOR (RF)	SST
030	<input type="checkbox"/> URINALYSIS, COMPLETE	UR
605	<input type="checkbox"/> URINE CULTURE & SENSITIVITIES	UR
212	<input type="checkbox"/> MICROALBUMIN, URINE	UR
	<input type="checkbox"/>	

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 _____