

### Home Draw Request Form

**Fax 727-733-3973 (8am – 4pm Monday – Friday)** **Phone: 727-733-5036**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Today’s Date: | | BC Client # | | | Office Requesting : | | | | | | **\*\* FAX OR E-MAIL TO** [**LAB2DOOR@BAYCARE.ORG**](mailto:LAB2DOOR@BAYCARE.ORG) **AT LEAST TWO DAYS IN ADVANCE TO ALLOW FOR SCHEDULING \*\*** | | | | | | | | | | | |
| Person Requesting & Phone: | | | | | | | | | | | | **Ordering Physician (first & last name):** | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | AddressCity /Zip : | | | | | | | | | | |
| **Last**: | | | | | |  | | | | | Middle: | Doctor’s Phone : (     ) | | | | | | | | | | |
| **First**: | | | | | | | | Birth date: | | | | Doctor’s Fax Number : (     ) | | | | | | | | | | |
| Social Security Number: | | | | Home phone no.: | | | | | | | Other Phone: | | | | Sex: | | | | **Results to Physician?** | | | |
|  | | | | (     ) | | | | | | | (     ) | | | | M  F | | | | **Call  Fax** | | | |
| Patient Street address: | | | | | | City: | | | | | | | State: | | | | | | | ZIP Code: | | |
|  | | | | | |  | | | | | | |  | | | | | | |  | | |
| Single  Mar  Div  Wid | | | | | Copy Results To: | | | | | | | | | | | | | | | | | |
| Special Instructions: | | | | | | | | | | | | | | | Fax Results to: | | | | | | | |
| **DIAGNOSIS CODE(S):** | | | | | | | | | | | | | | |  | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | |
| Subscriber’s name: | | | Insurance Name | | | | Address: | | | | | | | | Phone no.: | | | | | | | |
|  | | |  | | | |  | | | | | | | | (     ) | | | | | | | |
| Please indicate primary insurance | | | | |  | | | | | Medicare | | Medicaid | | | | | Self Pay | | | | Other | |
| Group no.: | | | Policy no.: | | | Other Insurance : | | | | | | | | | | | | | | | | |
|  | | |  | | | **Document claim address/submit front/back copy of insurance card** | | | | | | | | | | | | | | | | |
| **TEST INFORMATION** | | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Routine | STAT  Collect  Report | Timed Collection  Time: | | **Standing Order** | | | Start Date: | | | REQUESTED DRAW DATE: | | | | **Frequency**: | | | | End Date: | | CBC w/diff | CBC w/PLT No Diff | H & H | Magnesium | | Phosphorus | CK Total (Daptomycin monitoring) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Basic Metabolic Panel *(NA, K, CL, CO2, BUN, Creat,CA)* | | | | | | | | | Comp Metabolic Panel *(NA,K CL CO2 BUN, Creat, CA, TP, Alb, AST, Alk Phos, T Bili ALT)* | | | | | | | | | | | | | |
| Vancomycin  Trough  Random | | | | | | | | | Tobramycin  Trough  Random | | | | | | | | | | | | | |
| Amikacin  Trough  Random | | | | | | | | | Gentamicin  Trough  Random | | | | | | | | | | | | | |
| PT / INR  Patient on anticoagulant therapy | | | | | Other (separate tests with Comma) | | | | | | | | | | | | | | | | | |
| Other Continued : | | | | | | | | | | | | | | | | | | | | | | |
| Additional Information: | | | | | | | | | | | | | | | | | | *\*Note: Tests ordered within panels may also be ordered Individually* | | | | |
| ***For Lab Use Only*:** Soarian Entered by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_ Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | |
| Definition of “homebound” status | | | | | | | | | | | | | | | | | | | | | | |
| Synonymous with confined to the home, as for medical reasons. “204.1 – An individual does not have to be bedridden to be considered as confined to home. However, the conditions of these patients should be such that there exists a normal inability to leave the home, and consequently, leaving their home requires a considerable and taxing effort… It is expected in most instances, absences from the home that occur will be for the purpose of receiving medical treatment.” CMS: HHA Manual – Pub. 11, Revision 227  **I hereby confirm that this patient meets CMS Homebound criteria.** | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | |  | |  | | | | | |  |
|  | Provider’s Signature (REQUIRED) | | | | | | | | | | | | |  | | Date | | | | | |  |