

### Home Draw Request Form

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Today’s Date: | | BC Client # | | | | Office Requesting : | | | | | | | **\*\* FAX AT LEAST THREE DAYS IN ADVANCE TO ALLOW FOR SCHEDULING \*\*** | | | | | | | | | | | |
| Person Requesting & Phone: | | | | | | | | | | | | | | **Ordering**  **Physician:** | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | AddressCity /Zip : | | | | | | | | | | |
| **Last**: | | | | | | |  | | | | | | Middle: | Doctors Phone : (     ) | | | | | | | | | | |
| **First**: | | | | | | | | | Birth date: | | | | | Doctors 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 | | | | | | Patient on Anticoagulant | | | | | | | | | | | Copy Results To: | | | | | | | |
| Special Instructions: | | | | | | | | | | | | | | | | |  | | | | | | | |
| **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** | | | | | | | | | | | | | | | | | |
| If Medicare patient and diagnosis code does not support medical necessity, patient will be required to fill out an ABN form indicating that the patient has accepted responsibility for payment if charges are denied by Medicare | | | | | | | | | | | | | | | | | | | | | | | | |
| **TEST INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Routine | STAT | Timed Collection | | **Standing Order** | | Start Date: | | | REQUESTED DRAW DATE: | | | | **Frequency**: | | | End: | | CBC w/diff | CBC w/PLT No Diff | H & H | Chol Fract / Lipid Panel | | Digoxin | | Bun/Creat | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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)* | | | | | | | | | | | | | | |
| TSH 3rd Generation | | | | | | | | | | Absolute Neutrophil | | | | | | | | | | | | | | |
| PT / INR | | | | 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 | | | | | | | | | | | | | | | | | | | | | | | | |
| **\*\* Must be completed by ordering medical professional \*\*** | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 by the presence of my signature below.** | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | |  | |  | | | | | |  |
|  | Ordering Medical Providers Signature (REQUIRED) | | | | | | | | | | | | | | |  | | Date | | | | | |  |