**REQUEST FOR HOME VISIT SERVICES FORM**

In order for a patient to be considered for a possible home visit, the following information must be completed, including the reason for the home visit, and the form must be signed by the requesting provider. If the request meets our criteria for a home visit, we will then contact the patient and schedule a collection date and time.

Please print legibly:

Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I.\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this a standing order: Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Reason for home visit: (check one)

\_\_\_\_\_ Patient is completely non-ambulatory

\_\_\_\_\_ Patient was discharged from hospital and is non-ambulatory for \_\_\_\_\_ weeks

 (the need for a home visit will be reevaluated after \_\_\_\_\_\_ weeks)

Please note: If the patient can be transported to an EML location but has difficulty getting in and out of the care, they will NOT qualify for a home visit. We will offer these patients a car draw. We will draw their blood while they remain in the vehicle.

Requesting provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(no substitution permissible)

All documents, including the insurance information, lab request, and “Request for Home Visit Services’ sheet must be faxed to **738 – 6682:**

**Ephrata Medical Laboratory**

**Re: Home Visit Request**