  **Ephrata Community Hospital Laboratory**

 **Fax To: 717-738-6533**

 **Gettysburg Hospital Laboratory**

 **Fax To: 717-337-4236**

 **York Hospital Laboratory**

 **Fax To: 717-851-1443**

**□** Orthopedic Patient □ Non-Orthopedic Patient

Approximate Date to Be Done: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Patient Name SS# or Medical Record # Date of Birth

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

Address Home Phone #

**House Call Requirement:** This service is reserved for patients with significant difficulty leaving their home due to their medical condition and will be provided only when requested and authorized by a physician who certifies the need. Lack of transportation does not quality the patient for a house call. This service is not available on evenings, weekends or holidays.

**My signature and reason below confirm this patient is eligible for a York Hospital house call.**

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Physician Signature Physician PRINTED First and Last Name

COPY TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provide valid diagnosis code(s)** Specific orders are required for each visit. Standing

 □ \_\_\_\_\_\_\_\_\_\_\_\_\_ orders are not accepted for home bound patients.

 □ \_\_\_\_\_\_\_\_\_\_\_\_\_

 □ \_\_\_\_\_\_\_\_\_\_\_\_\_

 □ \_\_\_\_\_\_\_\_\_\_\_\_\_ **Test Orders**

 **□** Basic Metabolic Panel

 □ Comprehensive Metabolic Panel **Send copies of insurance cards. □** CBC & Auto Diff

 □ CBC; No Diff

**Include an Advanced Beneficiary Notice** □ Lipid Panel

**(ABN) for non-covered services.** □ Protime

 □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital Use Only □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phlebotomist ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date/Time of Draw \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lab-133 Revised 6/15/2023