[](javascript:ClickThumbnail(509))  **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