York Hospital
WellSpan

YORK HOSPITAL
LABORATORY SERVICES
HOUSE CALL REQUISITION

FAX TO: 717-851-3296

❑ 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 qualify the patient for a house call. This service is not available on evenings, weekends or holidays.

My signature and reason below confirms 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)

❑ _____
❑ _____
❑ _____
❑ _____

Send copies of insurance cards.

Include an Advanced Beneficiary Notice (ABN) for non-covered services.

Hospital Use Only
Phlebotomist ID _____
Date/Time of Draw _____

Specific orders are required for each visit. Standing orders are not accepted for home bound patients.

Test Orders

❑ Basic Metabolic Panel
❑ Comprehensive Metabolic Panel
❑ CBC & Auto Diff
❑ CBC; No Diff
❑ Lipid Panel
❑ Protime
❑ _____
❑ _____
❑ _____
❑ _____
❑ _____
❑ _____
❑ _____