140 58 St Suite 8D
Brooklyn, NY 11220
212-254-2300

**Serving the community since 1843**

**REQUEST FOR MEDICALLY NECESSARY HOME VISIT**
**FAX TO: 212-353-5140 PH # 212-353-5155**

By signing below, the physician requesting a home visit by laboratory phlebotomist is certifying that the patient is homebound (as defined by Medicare) and that both the home visit and lab tests that are being ordered are medically necessary.

**B&S CAN NOT PERFORM HOME VISIT UNLESS THE FORM IS COMPLETED IN FULL**

[ ] STAT **PLEASE PRINT CLEARLY** **DATE OF SERVICE** ____________

**LAST NAME**________________________ **FIRST NAME:**______________________________

**DATE OF BIRTH:** ______________ **[] M** **[] F**

**STREET ADDRESS:** ____________________________________________________________

**CITY:** __________________________________ **STATE** ______ **ZIP**__________

**PATIENT TELEPHONE #** ______________________________________________

**PATIENT MEDICARE #** ________________________________________________________

**STANDING ORDER:**

**[] 2X WEEK [] Q1 WEEK(S) [] Q2 WEEK(S) [] Q1 MONTH(S) [] Q2 MONTH(S)**
**[ ] 14 FASTING [ ] 15 NON-FASTING**

| | | | | | |
|---|---|---|---|---|---|
| [] | 8035 | **PTT** | [] | 92 | **T3 UPTAKE** |
| [] | 8034 | **PT + INR** | [] | 93 | **T4** |
| [] | 7502 | **CBC, DIFF, PLT** | [] | 95 | **TSH** |
| [] | 51 | **PHOSPHORUS** | [] | 96 | **T3 TOTAL** |
| [] | 54 | **URIC ACID** | [] | 101 | **FREE T4** |
| [] | 60 | **LDH** | [] | 108 | **PSA** |
| [] | 8121 | **CMP** ( Na, K, Cl, Glu, BUN, Cr, Ca, TP, Ab, TBili,, AP, AST, ALT | [] | 3051 | **DILANTIN** |
| [] | 8122 | **HEPATIC** (Ab, TBili, DBil, AP, AST, ALT, TP | [] | 105 | **DIGOXIN** |
| [] | 8015 | **LIPID PANEL** (Trig, Chol, HDL, LDL, Chol/HDL Ratio) | [] | 2064 | **VITAMIN D** (25 HYDROXY) |
| [] | 178 | **MAGNESIUM** | [] | 1035 | **SED RATE** (ESR) |
| [] | 116 | **GLYCO HGB AIC** | [] | 2060 | **RHEUMATOID FACTOR** |
| [] | 142 | **FBS** ( Fasting Glucose) | [] | 2303 | **STOOL OCCULT BLOOD** |
| [] | 8014 | **IRON PROFILE** ( IRON,TIBC,SAT,UIBC) | [] | 7500 | **URINALYSIS** |
| [] | 97 | **FOLATE** | [] | 10100 | **URINE CULTURE & SENSITIVITIES** |
| [] | 98 | **VITAMIN B12** | [] | 6468 | **MICROALBUMIN URINE** |
| [] | 99 | **FERRITIN** | [] | **OTHER TESTS** | |

**SPEC.REQUESTS OR INFO:** ____________________________________________

**DIAGNOSIS CODES (ICD-9)**____________________________________________

**PHYSICIAN NAME:**____________________________ **CLIENT#**______________________

**STREET ADRESS:**____________________________________________________

**CITY:** ____________________ **STATE:**__________________ **ZIP:** ______________

**PHYSICIAN TELEPHONE:** ____________________ **FAX #**______________________

**PHYSICIAN SIGNATURE:*** ______________________ **DATE:** ______________________

***This form must be signed and only the referring physician may sign. Original signature is required and SIGNATURE STAMP IS NOT PERMITTED.***

****48 HOURS NOTICE IS REQUIRED FOR ALL HOUSE VISITS****