TPHC
Texas Physician House Calls

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Lab Requisition Form

Patient name and

Patient Informatic

SSN :_____Name:_____

Address:	**Insurance Company Name:**
	Group Name _____Group # _____
Tel:	Policy ID _____

Date of Request: **Specimen to be collected the week of** **FASTING**

_____ _____ Yes No

Month Day Year

Is Patient of Frail Health (bedridden, Wheelchair bound) (Circle your choice) Yes No

Is Patient Unable to drive or leaving home is a major effort (Circle your choice) Yes No

Is there a Preference to Order through Home Health Yes No (Note: UA and URINE CULTURE are ordered through Home Health Only)

DIAGNOSIS CODES (Reason for Ordering) _____

TEST(s) Requested (Circle your choices)

CXR	**CBC**	**UA**
KUB	**CMP**	**URINE CULTURE**
TSH	**LIPID PANEL**	**PSA**
HbA,C	**MAMMOGRAM**	

Diagnosis Codes (Reason for Ordering):

_____

_____

Is Colonoscopy Required: Yes No Did Patient: Accept Refuse Complete

Nurse Practitioner Signature _____Date_____

Physician's Signature _____

Printed Name _____Date of Signature _____