

**Tender Care Phlebotomy, LLC**

103 Township Line Road

Rockledge, PA 19046

Phone: 267-763-1520 Fax: 267-825-7601

**HOUSE CALL REQUEST FORM**

\*Incomplete or Inaccurate information may delay order\*

**Please Print**

**Patient's Full Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone No:** \_\_\_\_\_ **Alt Phone No:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Sex:** Male or Female (Please circle)

**Insurance name:** \_\_\_\_\_ **ID No:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

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**PHYSICIAN INFORMATION**

**Physician Name:** \_\_\_\_\_ **NPI or UPIN #:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Physicians Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

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**TEST INFORMATION**

**ICD-10 Code(s):** \_\_\_\_\_

**Test Name(s):** \_\_\_\_\_

**Special Instructions:** \_\_\_\_\_

**Please Circle:**      **Fasting:**    YES      NO

**Frequency:** \_\_\_\_\_

**Start Date:** \_\_\_\_\_ **End Date:** \_\_\_\_\_

**Is Patient Medically Home Bound {Please Circle}**    YES      NO

**Doctor Signature:** \_\_\_\_\_