

## Princeton **Mobile Laboratory Service Request (BioMed<sup>DX</sup> Mobile)**

Princeton Biomedical Mobile Laboratory Service is intended as a service for patients who are unable to access a Patient Service Centre. Patients who meet one of the following criteria are eligible for Mobile Laboratory Service. Please select the appropriate criteria for service and fax this form along with a completed Laboratory Requisition to the appropriate Mobile Laboratory office.

- Patient is home and /or bed bound and leaving home would compromise the patient's health.
- Patient is unwell and a trip outside the home would cause physical distress.
- Patient has a mental health problem such as agoraphobia, debilitating anxiety, or other psychiatric condition that prevents him/her from leaving home.
- Other. Please provide reason .

Date:

Length of Service:

<b>Patient Name: (Last, First, Middle Initial )</b>	<b>To Agency:</b> Princeton Biomedical Laboratories <b>(BioMed<sup>DX</sup> Labs)</b> 1501 Lincoln Way, Pittsburgh, PA 15131 Tel: 412.678.1628 / Fax: 412.678.1384
Address for Care:   Tel: <input style="width: 50px;" type="text"/>	Physician office Address: <input style="width: 150px;" type="text"/>  Tel No:  FAX No:
Patient's Address (If not the same as above)  Tel: ( )	Referral Date:  Reported By: <input style="width: 50px;" type="text"/>
Complete Date of Birth:  Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Marital	<b>Medicare No.</b>
Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D	<b>Medicaid No.</b>
Responsible Relative or Friend:  Relationship:  Tel: ( )	<b>PPOM:</b>
<b>Diagnosis: (List primary first and date of onset)</b>	<b>Name of Subscriber: UR</b>
	<b>Other Insurance: Policy No. and Subscriber INS</b>

### MEDICAL ORDERS VERIFICATION

I certify that the above patient is under my care, requires that the above Home Health Services, and is confined to his home. These professional services are to be provided on an intermittent basis and I will review the established plan at least every two months. These services are related to the diagnosis stated above and conditions for which he/she received treatment while recently hospitalized.

Physician's Signature:	Date: / /	
Address:		
Tel:	UPIN No:	License No: