MEDLAB South

HOMEVISIT REQUEST

PHONE REQUEST

COMPULSORY **

** Patient's NHI or DOB: _____

** Patient's Name: _____

** Address: _____

_____

Phone: _____

** Date Required: _____

Requested By: _____

Phone: _____

** Requestor: _____

** Location of Form:

- ☐ To be emailed (timaru.homevisit@medlabsouth.co.nz)
- ☐ At the house
- ☐ At the Rest Home/Hospital

Completed form to be given to the H/V co-ordinator