MEDLAB South

Request for Domiciliary Visit

ALL BOOKINGS MUST BE EMAILED TO nelson.reception@medlabsouth.co.nz **by 12 midday the day prior to requested visit.**

Patient's Name: _____

Patient DoB and/or NHI: _____

Address: _____

_____

Resthome / Location – wing / room no.: _____

Visit Date – in the week starting: _____

Urgent (determined by Doctor only) **Yes** ☐ **No** ☐ (same or next day of request)

DOCTOR Authorising Visit:

Regular INR (Warfarin)? **Tick if yes** ☐

Regular other test? **Tick if yes** ☐

Fasting? **Yes** ☐ **No** ☐

Drug Level? **Yes** ☐ **No** ☐

Blood test request form in CMS? **Yes** ☐ **No** ☐

Blood test request form emailed to Medlab? **Yes** ☐ **No** ☐

Blood test request form held at Resthome / house? **Yes** ☐ **No** ☐

Any other information we might need to know?

_____

Eligibility Declaration

The above patient is housebound and has no other means of attending a Medlab Clinic.

Signed by Dr. _____

Medlab office use only

CONFIRMATION OF DOMICILIARY VISIT DATE: _____
(VISIT COULD BE AM OR PM FOR FASTING OR DRUG LEVELS)

CONFIRMATION (USUALLY AM) EMAILED: _____

SIGN: _____