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M-TEE'S MOBILE MEDICAL SERVICES

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MOBILE SPECIMEN COLLECTION & POC TESTING PHYSICIAN ORDER

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* This form serves as the official physician prescription for mobile clinical services *

1. PATIENT DEMOGRAPHICS

Patient Full Name: _____ DOB: ____/____/_____ Sex: [M] [F]

Phone Number: (____) _____-_____ Alt Phone: (____) _____-_____

Home Address: _____

2. REQUESTED SERVICES (Check all that apply)

MOBILE SPECIMEN COLLECTION (FOR OUTSIDE LAB ENTRY):

[ ] Routine Venipuncture / Blood Draw (Specify Tube/Test): _____

[ ] Specimen Pick-up & Courier Only (Patient self-collected urine/stool)

POINT-OF-CARE (POC) SCREENING (PERFORMED ON-SITE):

[ ] Urinalysis (Dipstick) [ ] Coag PT@ System (PT/INR)

[ ] Serenity Drug Cup (Non-DOT Screen) [ ] Curo L5 Kit (TC / Glucose)

[ ] Mission Hb Monitor (Hgb/Hct) [ ] Microalbumin 2-1 Strip (Kidney)

[ ] Acute Respiratory Swab (Flu/Strep/COVID)

3. CLINICAL INDICATION / DIAGNOSIS CODES (REQUIRED FOR INSURANCE BILLING)

ICD-10 Code(s): _____

Clinical Reason for Home-bound Status: _____

4. PHYSICIAN/PROVIDER AUTHORIZATION

Provider Name (Printed): _____ NPI #: _____

Clinic Name: _____ Fax #: _____

Provider Address: _____

I certify that the ordered laboratory/screening tests are medically necessary for the diagnosis and treatment of this patient. I authorize M-Tee's Mobile Medical Services to perform home-bound collection and/or POC testing as designated above.

Provider Signature: _____ Date: ____/____/_____