



# Laboratory Services

A Department of Rutland Regional Medical Center

160 Allen Street, Rutland, VT 05701 | www.RRMC.org | 802.747.1771 | Fax 802.747.3631

## OUTPATIENT REGISTRATION: NURSING HOME

FACILITY	
<input type="checkbox"/> Rutland Health & Rehab	<input type="checkbox"/> Genesis – MVC
<input type="checkbox"/> The Pines	<input type="checkbox"/> The Meadows
<input type="checkbox"/> Other: _____	

### TO BE COMPLETED BY NURSING HOME

Physician Signature: \_\_\_\_\_ Physician Name Printed: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Nursing Home Staff Signature (On behalf of Physician): \_\_\_\_\_ Date/Time: \_\_\_\_\_

Test/Procedure: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ Specimen Type: \_\_\_\_\_ Time Obtained: \_\_\_\_\_

Test/Procedure: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ Specimen Type: \_\_\_\_\_ Time Obtained: \_\_\_\_\_

Test/Procedure: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Test/Procedure: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

FAX RESULTS: _____
STAT: _____

### PATIENT / FACILITY INFORMATION

Patient Name: \_\_\_\_\_ Sex:  M  F Social Security #: XXX-XX-\_\_\_\_\_ DOB: \_\_\_\_\_

Guarantor Name, Address and Phone #: \_\_\_\_\_

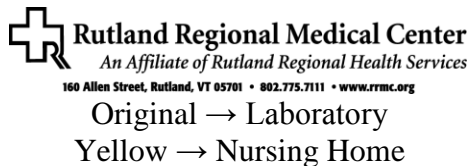
### PATIENT INSURANCE INFORMATION

<input type="checkbox"/> Medicare Patient is Level 1 (Bill Nursing Home)	<input type="checkbox"/> Patient is not Level 1 (Complete Insurance Information Below)
---	---

Primary Insurance Company Name:	
Mailing Address:	Phone Number:
	Policy #: _____ Group #: _____
Subscriber Name:	Subscriber Relationship to Patient:

Secondary Insurance Company Name:	
Mailing Address:	Phone Number:
	Policy #: _____ Group #: _____
Subscriber Name:	Subscriber Relationship to Patient:

Form #2748 Created 10/03 Rev 9/04, 2/09, 1/15 and 8/16



Patient Label
---------------