Respiratory Therapy Department
Order Form

Please follow the steps below, complete this form and FAX to the Respiratory Therapy Department at **932-3499**. If you have any questions please feel free to contact us at **932-3290**. Thank you.

1. Patient Name: _____

2. Date Ordered: _____ Pt Phone: _____

Age: _____ Sex: _____ Height: _____ Weight: _____ Date of Birth: _____

Physician Name (print) _____Signature_____

Insurance Plan(s)_____

AUTHORIZATION ATTACHED _____ **NO PRIOR AUTHORIZATION REQUIRED** _____

Clinical Diagnosis: _____ ICD-10 Code: _____

Any known allergies:_____ Hemoglobin Level: _____

PHYSICAN OFFICE PHONE _____ FAX REPORTS: _____

3. **Indicate which procedure you want us to perform on the patient.**

a. _____ Full Pulmonary Function

Includes: 94060 Bronchospasm Evaluation (Pre & Post TX Spirometry Flow Volume Loop)
94729 CO2 / Membrane Diffuse Capacity
94726 Body Plethysmography (Lung Volume)

Must be checked **Medication to be given: 2.5mg Albuterol Yes_____No___**

b. _____ 94060 Bronchospasm Evaluation (Pre & Post TX Spirometry Flow Volume Loop)
c. _____ 94729 CO2 / Membrane Diffuse Capacity
d. _____ 94375 Flow Volume Loop (** ***No Medication given with this test*** **)
e. _____ 94761 6 Minutes Ambulation O2
f. _____ 36600 Arterial Blood Gas @ Oxygen FiO2 _____ % or
Flow rate _____ LPM or Room Air _____
g. _____ 93005 EKG