



Please follow the steps below, complete this form and fax to the Respiratory Therapy Department at (808) 491-0300. Upon receipt we will call the patient and schedule the appointment. If you have any questions, please feel free to contact us at (808)322-4431. Thank you

## Respiratory Therapy Department Order Form

Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_ Patient Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Clinical Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Insurance Plan (s): \_\_\_\_\_ Authorization #: \_\_\_\_\_

Many tests require precertification, please provide precertification # if required.

1. Indicate which procedure would best diagnose your patient.

☐ Simple Spirometry, CPT 94010

☐ Spirometry Pre & Post Bronchodilator\* (Please order bronchodilator below) CPT94060

☐ Indicate Bronchodilator Albuterol 2.5mg Nebulized, CPT 94640

☐ Complete PFT (Spirometry/ Lung Volumes/ DLCO) CPT 94010, 94727, 94729

☐ Complete PFT Pre and Post Bronchodilator\* (Please order bronchodilator below)

Spirometry/ Lung Volumes/ DLCO CPT 94010, 94727, 94729

☐ Indicate bronchodilator Albuterol 2.5 mg nebulized, CPT 94640

☐ 6 Minute Walk Test ☐ EKG

☐ Arterial Blood Gas on Room Air, \_\_\_\_\_ lpm or \_\_\_\_\_ FiO2

2. What you should tell your patient before you order the pulmonary function test.

The RT department will be calling to schedule testing with the patient. They will ask that the patient refrain from respiratory medications, caffeine, and smoking for 6 hours prior to the test.

Testing can take up to 90 minutes.

Physician Name (Print): \_\_\_\_\_ Physician Signature: \_\_\_\_\_

Fax Report to: \_\_\_\_\_ Date: \_\_\_\_\_

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