Phone: 932-3860 Fax: 932-3865

Respiratory Therapy Order Form

Please complete all sections below, and **FAX to the Pulmonology Clinic at 932-3865**
If you have any questions, please feel free to contact us at **932-3860**

1. Patient Name: ____

2. Date Ordered: ______________________ Patient Phone: _______________

   Age: _____ Sex: _______ Height: ______Weight: ______ Date of Birth: _____________

   Provider Name (print): ____________________ Signature: __________________

   Insurance Plan (s): ____

   AUTHORIZATION ATTACHED **NO PRIOR AUTHORIZATION REQUIRED**

   Clinical Diagnosis: _________________________ ICD-10 code: _______________

   Any Known Allergies: ____________________ Hemoglobin Level: _______________

   Physician Office Phone: _________________ Fax: ___________________________

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

   a. **Full Pulmonary Function without MVV *(most common)***
      - 94060 Bronchospasm Evaluation (Pre-& Post TX Spirometry Flow Volume Loop)
      - 94729 CO2/Membrane Diffuse Capacity
      - 94726 Body Plethysmography (Lung Volume)

   b. Full Pulmonary Function with MVV
      - 94200 Maximal Voluntary Ventilation (including all above tests/CPTs)

Must select:** ☐ **Medication to be given: 2.5mg Albuterol INH

94060 Bronchospasm Evaluation (Pre-& Post TX Spirometry Flow Volume Loop)

94729 CO2/ Membrane Diffuse Capacity

94375 Flow Volume Loop (No Medication given with this test)

94761 6 Minutes Ambulation O2

36600 Arterial Blood Gas @ Oxygen FIO2 __________% **or**
Flow rate __________ LMP or Room Air __________

93005 EKG

Updated 9/8/2022