# Respiratory Therapy Order Form

Please complete all sections below, and **FAX to the Respiratory Therapy Department at 932-3499**
If you have any questions, please feel free to contact us at **932-3290**

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***

   c. _____ 94060 Bronchospasm Evaluation (Pre-& Post TX Spirometry Flow Volume Loop)
   d. _____ 94070 Bronchospasm Evaluation Multiple (Bronchial Provocation Test)
   e. _____ 94729 CO2/ Membrane Diffuse Capacity
   f. _____ 94375 Flow Volume Loop (No Medication given with this test)
   g. _____ 94761 6 Minutes Ambulation O2
   h. _____ 36600 Arterial Blood Gas @ Oxygen FIO2 __________% **or**
   Flow rate __________ LMP or Room Air __________
   i. ______ 93005 EKG

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