Pulmonary Function Requisition

Referring Physician Name: (print first, last)

Additional Reports to:

Diagnosis:

- Full PFT
- Flow-Volume Loop
- Check if bronchodilator NOT desired
- Diffusing Capacity
- Supine Flow Volume Loop
- Lung Volumes
- MIP/MEP

Symptoms:

- Cough
- Wheezing
- Dyspnea
- Effort intolerance

Smoker:

- No
- Yes _____ packs/day for _____ years
- Ex-smoker - quit for _____ years - was _____ packs/day for _____ years

Medications:

- Bronchodilators
- Steroids
- Beta blockers

Other Tests:

- bronchial provocation (Methacholine Challenge) – must have flow-volume loop + bronchodilator done first
- 6 minute walk test (cannot be used to qualify patient for home oxygen, use IEA below)
- air hypoxia study – patient must by flying within the next 3 months
- shunt study
- ABG’s (arterial blood gases) – for home O₂ assessment or pre-op
- independant exercise assessment (IEA) for home oxygen
  
  Do on Room Air ____________ on O₂ ____________

Should test indicate qualification for Home Oxygen, arrangement for oxygen set up may be made unless otherwise indicated.

- No Home Oxygen set up without order from attending physician

FiO₂ | pH | PCO₂ | PO₂ | HCO₃⁻ | Be | O₂ Sat
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Physician’s Signature

Bronchodilation given according to medical directives Bi-Rt by: (print first, last)

Test Date: _____/_____/_____ by: (print first, last) ___________________________ Signature: ___________________________ RRT

Progress Notes:

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

By: (print first, last) ___________________________ Signature: ___________________________ Date: _____/_____/_____