RESPIRATORY REQUISITION FORM
Office: (406) 582-1111  Fax: (406) 582-1112
See “HOW IT’S DONE” at: www.pftMT.com

PATIENT NAME: ______________________________________________  DOB: ______________________

CONTACT NUMBER: ___________________________________________

SELECT TEST(S):

___ Spirometry
___ Spirometry and Flow Volume Loop
___ Spirometry w/ Bronchodilator
___ Fractional Exhaled Nitric Oxide (FeNO)
*may not be covered by all insurances*

TESTS AVAILABLE AFTER 8/15/18:

___ Full PFT [Spirometry w/ Bronchodilator, Lung Volumes, and Diffusing Capacity (DLCO)].
___ PFT with Lung Volumes [Spirometry w/ Bronchodilator, Lung Volumes]
___ PFT with DLCO [Spirometry w/ Bronchodilator, Diffusing Capacity (DLCO)]

SELECT UP TO 4 DIAGNOSTIC INDICATION(S):

SIGNS/SYMPTOMS:

☐ R05 – Cough  ☐ R06.2 – Wheezing
☐ R06.02 – Shortness of Breath  ☐ Other: _________________________________

☐ J43.9 – Emphysema, unspecified (please select additional signs/symptoms)
☐ J44.9 – Chronic Obstructive Pulmonary Disease, unspecified (please select additional signs/symptoms)
☐ J45.909 – Unspecified asthma (please select additional signs/symptoms)

Instruct patient to avoid any bronchodilator medications for at least 4 hours pre-test. These may include, but are not limited to: Albuterol, Proventil, DuoNeb, Xopenex, Advair, Foradil, and Serevent.

Ordering Clinician’s Printed Name: _______________________________________________________

Ordering Clinician’s Signature: ___________________________  Date: ___________