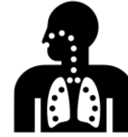
ALLERGY & ASTHMA
CONSULTANTS OF MONTANA

pft
at ALLERGY & ASTHMA



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
- ☐ **R06.02** – Shortness of Breath
- ☐ **R06.2** – Wheezing
- ☐ 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: ___________