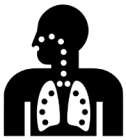
ALLERGY & ASTHMA
CONSULTANTS OF MONTANA

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: _____

Patient Contact Number: _____ Height: _____ Weight: _____

[for AACMT use only, AACMT Account Number: _____]

Pulmonary Function Testing (PFTs)

☐ **Full PFT [Spirometry - Pre & Post Bronchodilator, Flow Volume Loop, Lung Volumes, and Diffusing Capacity (DLCO)]**

Spirometry

☐ **Spirometry** - **Pre & Post Bronchodilator**

☐ **Spirometry** - with **Flow Volume Loop**

☐ **Spirometry**

FeNO

☐ **Fractional Exhaled Nitric Oxide** (FeNO may not be covered by all insurances)

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*)

Ordering Clinician's Signature: _____ Date: _____

Ordering Clinician's Printed Name: _____

Results faxed to (Office Name & Fax Number): _____

_____

Instruct patient to avoid bronchodilator medications for at least 4 hours pre-test. These may include, but are not limited to: Albuterol, Xopenex, DuoNeb, Foradil, Serevent, Arcapta, Advair, AirDuo, Breo, Dulera, Symbicort, Anoro, Bevespi, Stioloto, Utibron, Trelegy, Atrovent, Seebri, Incruse, Spiriva, Tudorza, Combivent.