CARDIOPULMONARY TEST REQUISITION
PULMONARY TREATMENT/DIAGNOSTICS

Patient Name (Last, First MI):	Sex: ___ Male ___Female	Date of Birth:	Patient Phone#:

Weight:	Height:	Smoking Hx: ___Current Smoker ___Former Smoker ___Never Smoker

Ordering Physician:	Ordering Provider Phone#	Fax results to:

Physician/NP/PA Signature: ________________________________ Date: _____/_____/______

Primary Insurance:	ID#:	Subscriber:
Secondary Insurance:	ID#:	Subscriber
Authorization Required? ___ Yes ____No	If authorization required, please attach copy of authorization	

Indicate diagnosis/signs/symptoms necessitating testing

	Diagnosis
	Acute bronchitis J20.0
	Asthma, cough variant J45.991
	Asthma, moderate, persistent J45.40
	Asthma, unspecified J45.901
	COPD J44.0
	Cough R05
	Interstitial pulmonary disease, unsp J84.9
	Other long-term (current) drug tx Z79.899
	Pulmonary fibrosis J84.10
	Pulmonary Hypertension, unsp I27.20
	Shortness of breath R06.02
	Wheezing R06.2
	Preoperative respiratory examination Z01.811*
	Other_______________________________

*If testing for preoperative clearance, please also **indicate diagnosis for planned surgery under 'Other'**

Requested Order:

	Order	Code
	6-minute walk	94618
	Arterial blood gas LPM	82803
	Arterial blood gas Room Air	82803
	Complete PFT	94729, 94726, 94060
	MDI Instruction w/wo spacer	94664
	Nebulizer Treatment (SVN) 2.5 mg Albuterol	94640
	Nebulizer Treatment (SVN) 3mL DuoNeb	94640
	Nocturnal Oximetry study	94762
	PFT Pre/Post bronchodilator	94060
	Spirometry only	94010
	Sputum Induction	94640
	Other:	

Additional pertinent PMH:

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Hospital Use Only

Order to preauthorization review: ____/_____/_________ by: ______________________

Insurance verified: ____/_____/____________ by: _______________________________

Pre-Authorization verified: _____/_____/_________ by: ______________________________

Scheduled date: _____/_____/____________

Patient Label

6640 Kaniksu Street
Bonners Ferry, ID 83805
Phone: (208)267-3141 x4283
Fax: (208)267-4857

Cardiopulmonary Test Requisition
Pulmonary Treatment/Testing
PO. REG