

FHSH Pulmonary Function Scheduling Office: Phone (559) 433-8001, Fax (559) 433-8369

Patient Name: _____ Date of Birth: _____

Patient Address: _____ City/Zip Code: _____

Patient Phone Number: _____ Mobile Phone Number: _____

Referring Physician (Print Name): _____ Phone Number: _____

Diagnosis (specific): _____ ICD-10 Code: _____

Please include current demographics and insurance/authorizations with referral

Please mark all boxes that apply (*American Thoracic Society procedure names):

- ☐ **1. Complete Pulmonary Function With Bronchodilator:** Includes options 3,4,5 below.
- ☐ **2. Complete Pulmonary Function Without Bronchodilator:** Includes options 4,5,6 below.
- ☐ **3. Spirometry* With Bronchodilator Response Testing** (Spirometry – Pre and Post):
With Levalbuterol 1.25 mg/3 ml via nebulizer
- ☐ **4. Measurement of Lung Volumes*** (Functional Residual Capacity): Will be performed by either Plethysmography or Nitrogen Washout.
Include **Airway Resistance [RAW]*** by Plethysmography (Airflow Resistance)? ☐ Yes ☐ No
- ☐ **5. Single-Breath Carbon Monoxide Uptake in the Lung*** (Carbon Monoxide Diffusing Capacity – DLCO with Spirometry). Include **Hemoglobin and Hematocrit (H/H)** for DLCO correction? ☐ Yes ☐ No
- ☐ **6. Spirometry* Without Bronchodilator Response Testing** (Spirometry – Simple)
- ☐ **7. Percutaneous Arterial Blood Gas Sampling*** (Arterial Blood Gases [ABG]):
On ☐ Room Air ☐ Oxygen (O2) _____ lpm
- ☐ **8. Maximum Respiratory Pressures*** (Maximum Inspiratory/Expiratory Pressure* [MIP/MEP])
A primary procedure must accompany an order for a MIP/MEP.
- ☐ **9. 6-Minute Walk Test*** (Pulmonary Stress Test): If SpO2 drops to less than 89%, O2 will be titrated to keep SpO2 greater than 89% or _____. Unless specified, O2 titration will not be performed on Pulmonary Hypertension patients.
- ☐ **10. Exercise Test for the Assessment of Desaturation*** (Home O2 Evaluation Desaturation Screen/Oxygen Titration):
If SpO2 drops to less than 89%, O2 will be titrated to keep SpO2 greater than 89% or _____.
- ☐ **11. Frailty Testing** (5-Meter Walk)

Special needs the patient may have: _____

Date: _____ **Time:** _____ **Physician Signature:** _____ **National Provider Identifier:** _____

Respiratory Therapy
Pulmonary Function Test Referral Form

