PULMONARY FUNCTION TESTING REQUISITION

ALL TESTS MUST BE SCHEDULED BY THE REFERRRING PHYSICIAN'S OFFICE, NOT BY THE PATIENT

☐ **Mary Parkes Center for Asthma, Allergy & Pulmonary Care**
400 Red Creek Drive, Suite 110
Rochester, NY 14623
Phone (585) 486-0147 Fax (585) 486-0673

☐ **Strong Memorial Hospital**
601 Elmwood Avenue, Box 692
Rochester, NY 14642
Phone (585) 275-4161 Fax (585) 273-1171

PATIENT NAME: _____ **DATE OF BIRTH:** _____

ORDERING PHYSICIAN: _____ **PHONE #:** _____ **FAX #:** _____

PHYSICIAN'S SIGNATURE: _____

Pulmonary Function Tests: **** ***PLEASE GIVE PATIENT INSRUCTION SHEET*** *****

A ☐ Complete Pulmonary Function Tests **(This will include items B - G)**
B ☐ Spirometry (FEV_1, FVC, $FEF_{25-75\%}$)
C ☐ Slow Vital Capacity
D ☐ Maximum Voluntary Ventilation
E ☐ Lung Volumes: Functional Residual Capacity Measurement
F ☐ Airways Resistance (Body Box)
G ☐ Carbon Monoxide Diffusing Capacity (DLCO)

H ☐ Bronchodilator Response – Spirometry with Response to Bronchodilators

Other Studies:

I ☐ Pulse Oximetry at Rest ☐ Room Air ☐ On Oxygen _____ liters
J ☐ Pulse Oximetry with Ambulation (assess oxygen needs) ☐ Room Air ☐ On Oxygen _____ liters
K ☐ **Arterial Blood Gases ***** ☐ Room Air ☐ On Oxygen _____ liters
***** (only done at SMH location)**
L ☐ Maximum Inspiratory and Expiratory Pressures (measures respiratory muscle strength)

M. Methacholine Airway Challenge Testing: **** PLEASE GIVE PATIENT INSRUCTION SHEET *****
☐ Asthma ☐ Unexplained cough ☐ Bronchial allergy

Please check all applicable diagnoses:

☐ Abnormal arterial blood gases
☐ Abnormal chest x-ray/CT
☐ Asthma
☐ Atelectasis
☐ Bronchiectasis - (with acute exacerbation)
☐ Bronchiectasis- (without acute exacerbation)
☐ Bronchiolitis
☐ Bronchitis – Acute
☐ Bronchitis – Chronic
☐ COPD
☐ Cough
☐ Cyanosis
☐ Cystic Fibrosis
☐ Disease of respiratory system (not elsewhere classified)
☐ Disorders of diaphragm
☐ Dyspnea

☐ Emphysema
☐ Heart failure
☐ History of respiratory disease
☐ Hypoxemia
☐ Idiopathic pulmonary fibrosis
☐ Kyphosis
☐ Lung Cancer
☐ Lung Lesion
☐ Lupus (systemic erythematosus)
- **Neuromuscular disease:**
  ☐ Amyotrophic lateral sclerosis
  ☐ Guillain-Barre syndrome
  ☐ Muscular dystrophy
  ☐ Myasthenia gravis
  ☐ Other specified paralytic syndrome
☐ Pleurisy
☐ Pulmonary embolism/infarction
☐ Pulmonary Fibrosis

☐ Pulmonary HTN - primary
☐ Pulmonary HTN - secondary
- **Pneumoconiosis:**
  ☐ Coal worker's
  ☐ Due to silica
  ☐ Due to inorganic dust
  ☐ Unspecified
  ☐ Radiation Fibrosis
☐ Scoliosis
☐ Stridor
☐ Toxic effect of gases _____ (specify)
☐ Toxic effect of medication
- **Transplant:**
  ☐ Heart
  ☐ Lung
☐ Wheezing
☐ Other _____

PLEASE KEEP ORIGINAL FORM FOR YOUR PATIENT CHART

TEST DATE:_____TIME_____