PULMONARY FUNCTION TESTING REQUISITION

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Please provide demographic information from your office.

Diagnosis: ___________________________
Date of Request:_______________________
Referring Physician: ____________________
Telephone number: _____________________

Requested Testing:

Full pulmonary function testing: Spirometry before and after bronchodilators, residual volume, total lung capacity, diffusion capacity (DLCO) and airway conductance and resistance. Recent Hemoglobin if available: ____

Spirometry before and after bronchodilators

Pulse oximetry: Resting and Ambulatory

Maximal voluntary ventilation or MVV.

Home sleep monitoring, level 4 screening. This tests for apnea, but does not differentiate between obstructive and central. If positive, I would recommend an in lab titration.

Stat interpretation requested, two business hour turn around.