

General

Patient Name _____ DOB _____ Height _____ Weight _____ Phone # _____

Order Start Date _____ Order Expiration Date _____

Allergies: _____

Guidelines for Ordering:

1. Send **FACE SHEET** and **H&P** or most recent chart note.

2. Test Type

DIAGNOSIS CODE:

????????????

Pulmonary Function Test Type:

- Spirometry
- Spirometry Pre/Post Bronchodilator (*must order bronchodilator below*)
- Diffusion Capacity (DLCO) (*must order spirometry*)
- Methacholine Challenge (*must order methacholine & albuterol/xopenex below*)
- Maximal Voluntary Ventilation (MVV)
- Maximal Inspiratory Pressure/Maximal Expiratory Pressure (MIP/MEP)

Medication Order (*for pre/post bronchodilator spirometry, Methacholine Test or adverse reaction*):

- Albuterol 2.5mg/3mL Neb Soln
- Xopenex (Levalbuterol) 1.25 mg/3 mL
- Methacholine (*Order for Methacholine test only*)

MANAGEMENT OF SIDE EFFECTS:

If adverse reaction (Lightheadedness, dizziness, chest pain, shortness of breath, wheezing, fatigue): Stop Pulmonary Function Test and monitor patient further. If symptoms persist or for Respiratory Distress, administer Albuterol 2.5mg / 3mL neb solution. Activate Hospital Rapid Response Team.

Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patient identified on this form.

I hold an active, unrestricted license to practice medicine in _____ (*specify state*)

My physician license number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medication described above for the patient identified on this form.



Provider Signature: _____

Date _____

Printed name: _____

Phone: _____

Fax: _____

KVH Provider Co-signature:

**Required for all external orders*

Provider Signature: _____

Date _____

Printed name: _____