

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:

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

Respiratory Care Services Orders:

- Six-Minute Walk Test
- Oxygen Titration
- Arterial Blood Gas
- Sputum Induction (*order medication below*)
- Fractional Exhaled Nitric Oxide (FeNO)
- Respiratory Education (*please specify on page 2 what you would like patient educated on*)

Medication Order (for sputum induction only):

Sodium Chloride 3% Neb Soln.

MANAGEMENT OF SIDE EFFECTS:

If adverse reaction (Lightheadedness, dizziness, chest pain, shortness of breath, wheezing, fatigue): Stop 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: _____