

CARDIOPULMONARY TEST-REQUISITION

Cardiology

Patient Name: _____ (Last, First, MI)		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB: _____
Weight: _____	Smoking History: <input type="checkbox"/> Current Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Never Smoker	Patient Phone Number: _____	
Ordering Physician/NP/PA: _____		FAX Results to: _____	
Diagnosis/Pertinent PMH: _____			

Please check correct box for ICD-10 Diagnosis Code for each test ordered. Please indicate if testing is for preoperative clearance and provide diagnosis for which surgery is planned.

Step 1-Select the Diagnosis of Your Choice:

- | | |
|---|--|
| <input type="checkbox"/> (I48.0) Paroxysmal Atrial Fibrillation
<input type="checkbox"/> (I48.19) Other Persistent Atrial Fibrillation
<input type="checkbox"/> (I48.3) Typical Atrial Flutter
<input type="checkbox"/> (I44.1) Atrioventricular Block, Second Degree
<input type="checkbox"/> (I44.39) Other Atrioventricular Block
<input type="checkbox"/> (I45.81) Long QT Syndrome
<input type="checkbox"/> (47.1) Supraventricular Tachycardia
<input type="checkbox"/> (I47.2) Ventricular Tachycardia
<input type="checkbox"/> (R00.2) Palpitations
<input type="checkbox"/> (R55) Syncope and Collapse
<input type="checkbox"/> (I49.3) Ventricular Premature Depolarization
<input type="checkbox"/> (I49.1) Atrial Premature Depolarization
<input type="checkbox"/> Other ICD-10: _____ | <input type="checkbox"/> Event Monitor
<input type="checkbox"/> Holter Monitor (24 hr.)
<input type="checkbox"/> Holter Monitor (48 hr.)
<input type="checkbox"/> Holter Monitor (7 day)
<input type="checkbox"/> Holter Monitor (14 day)
<input type="checkbox"/> 12 Lead ECG/EKG with Interpretation
<input type="checkbox"/> Echo Complete
<input type="checkbox"/> Echo Complete w/Left Ventricular Strain
<input type="checkbox"/> Echo Limited |
|---|--|

Step 2- Requested Order:

Step 3: Physician/NP/PA Signature: _____ **Date:** ____/____/____

Step 4: Fax order to Boundary Community Hospital. We will call patient and schedule the appointment.

Cardiopulmonary Department FAX: 208-267-4857 PHONE: 208-267-3141 ext. 4283

***All outpatients testing may be performed in the facility of your choice*



BOUNDARY
Community Hospital
6640 Kaniksu Street
Bonners Ferry, ID 83805
Phone: (208)267-3141 x4282
Fax: (208)267-4857

Cardiopulmonary Test Requisition.



Rev 05/19/22/SDJ/BOU-011

CARDIOPULMONARY TEST-REQUISITION

Pulmonary

Patient Name: (Last, First, MI)		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB:
Weight:	Smoking History: <input type="checkbox"/> Current Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Never Smoker	Patient Phone Number:	
Ordering Physician/NP/PA:		Fax Results to:	
Diagnosis/Pertinent PMH:			

Please check correct box for ICD-10 Diagnosis Code for each test ordered. Please indicate if testing is for preoperative clearance and provide diagnosis for which surgery is planned.

Step 1-Select the Diagnosis of Your Choice:

- (J20.0) Acute Bronchitis
- (J45.40) Asthma, Moderate, Persistent
- (J45.901) Asthma, Unspecified
- (J45.991) Cough Variant Asthma
- (J84.9) Interstitial Pulmonary Disease, Unspecified
- (J84.10) Pulmonary Fibrosis
- (R05) Cough
- (J44.0) COPD
- (R06.2) Wheezing
- (R06.02) Shortness of Breath
- (Z79.899) Other Long Term (current) Drug Therapy
- (I27.20) Pulmonary Hypertension, Unspecified
- Other ICD-10: _____

Step 2- Requested Order:

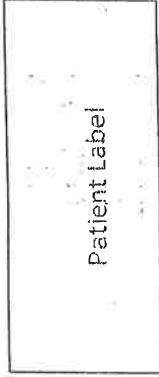
- Spirometry Only
- PFT Pre and Post Bronchodilator
- Complete PFT
 - Diffusing Capacity
 - Total Lung Volume
 - Pre/Post
- MDI Instruction with/without Spacer
- Arterial Blood Gas _____ LPM or _____ Room Air
- Sputum Induction
- Nocturnal Oximetry Study
- Nebulizer Treatment (SVN): _____ 2.5mg
- Albuterol or _____ 3ml Duoneb
- Other: _____

Step 3: Physician/NP/PA Signature: _____ **Date:** ____/____/____

Step 4: Fax order to Boundary Community Hospital. We will call patient and schedule the appointment.

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