Patient's Name _____ DOB _____ Phone _____

Date of Exam _____ Scheduled Time _____ Physician's Phone # _____ / Fax # _____

For scheduled exams, report to the East Tower - Patient Registration Desk 45 minutes prior to your appointment. Bring this request with you when you come to the hospital. If you have questions, please call 389-1202 or 389-1852.
Patients arriving late or unprepared may be required to reschedule or may experience an extended waiting period.

PATIENTS MUST BRING LIST OF MEDICATIONS CURRENT TAKING. "See attached"

REQUESTED EXAMINATION:

Pulmonary Lab 389-1202 Fax 389-1725	Pulmonary Rehab 389-1236 Fax 389-1537	NeuroDiagnostics 389-1728 Fax 389-1391
☐ Spirometry (PFT) ☐ Spirometry Pre/Post Bronchodilators (No Bronchodilators prior to test) ☐ Complete PFT (spirometry pre/post bronchodilator, lungs volumes by body box plethysmography or N2 washout, DLCO). ☐ Lung Volumes (N2-Washout or Body Box) ☐ DLCO (Diffusion Lung Capacity) ☐ MIP/MEPS (PIMAX / PEMAX) (Muscle Strength Measurements) ☐ Complex stress test (CPX) (Physician needs to be present) ☐ Exercise Challenge Test (Pulmonary stress testing: simple) ☐ Bronchospasm provocation evaluation (Methacholine Challenge Test) ☐ Activity w/Spao2 (multiple determination) ☐ Respiratory Treatment: Medication _____ Dosage _____	☐ Pulmonary Rehab w/ exercise Sleep Lab 425-6400 Fax 630-2845 ☐ Attended Polysomnogram, sleep staging with 4 or more parameters of sleep ☐ Attended Polysomnogram, sleep staging with 4 or more parameters of sleep, CPAP/Bilevel ventilation titration. ☐ Multiple Sleep Latency Testing	☐ EEG ROUTINE (EEG AWAKE AND DROWSY, EEG AWAKE AND SLEEPY ,EEG IN COMA OR ASLEEP) ☐ EXTENDED EEG EEG 41-60 MINUTES EEG GREATER THAN 1 HOUR ☐ EEG with Video each 24hours ☐ BAER - Evoked Potential ☐ VER - Visual Evoked Potential ☐ SEP - Upper Extremities ☐ SEP - Lower Extremities Hearing Screen Exams ☐ Otoacoustic Emissions ☐ Automated Auditory Brainstem Response _____ ☐ Other

Diagnosis (Please write out diagnosis): _____
(Do not use Rule Out, Possible or Pre-op as diagnosis)

ICD-10 Code(s): _____

Is patient diabetic? ☐ No ☐ Yes

Does patient have allergies?
☐ No If "Yes", list: _____

Is patient Pregnant? ☐ No ☐ Yes

Study to be read by: _____ LMP _____

Signature of Referring MD _____ Date / Time _____

VALLEY BAPTIST OUTPATIENT SERVICES
Respiratory Care, Sleep Lab & Neurodiagnostics
Physician Orders