



Langone Medical Center
 NYU Pulmonary and Critical Care Associates

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PULMONARY FUNCTION TEST LAB REQUISITION FORM

PATIENT: _____	REFERRING PROVIDER: _____
DATE OF BIRTH: _____	ADDRESS: _____
INSURANCE CO: _____	TEL: _____ FAX: _____
MEMBER ID #: _____	CLINICAL INFORMATION: _____ _____ _____ _____
GROUP #: _____	
DATE: _____ TIME: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
PRECERT #: _____	

PULMONARY FUNCTION TESTING	DIAGNOSIS
<input type="checkbox"/> Complete PFT (Includes Measurement of Lung Volumes, Spirometry and Diffusing Capacity)	<input type="checkbox"/> 786.05 Shortness of Breath
<input type="checkbox"/> Spirometry (pre/post bronchodilator admin)	<input type="checkbox"/> 493.90 Asthma
<input type="checkbox"/> Spirometry (without bronchodilator)	<input type="checkbox"/> 793.1 Abnormal CXR Findings
<input type="checkbox"/> Diffusion Capacity	<input type="checkbox"/> 496 COPD
<input type="checkbox"/> Exercise Oximetry	<input type="checkbox"/> 786.2 Cough
<input type="checkbox"/> Plethysmography	<input type="checkbox"/> Other (Please Specify):
<input type="checkbox"/> Six Minute Walk Test	

Many tests require pre-certification. Please provide the pre-cert # (if required) prior to the scheduled date of the test. First-time patients should arrive 15 minutes before their appointment to complete registration forms.

SPECIAL INSTRUCTIONS: _____

PHYSICIAN SIGNATURE: _____