Arkansas Children's
HOSPITALS · RESEARCH · FOUNDATION

Northwest Childrens Hopsital
Referred Patient Requisition/ Order/ Referral
Ancillary Services-Pulmonary Lab
Phone: 479-725-6995

NOTE: ORDERS WILL NOT BE PROCESSED WITHOUT THE APPROPIATE INFORMATION COMPLETED AND THE PHYSICIAN'S SIGNATURE AFFIXED.

Patient Name:			Insurance Company:
Patient Adress:			Insurance Policy #:
			Insurance Referral #:
Patient Birthdate:			Medicaid Policy #:
Phone #:			Pre Authorization #:
Mother's First Name:			NPI #:
ACH Medical Record #:			Requested Date of Service:
Referring/ Ordering MD:			
Street:			
City:	State:		Zip:

CIRCLE THE NUMBER AND WRITE THE APPROPIATE DIAGNOSIS CODE IN THE SPACES BELOW.

ALL ORDERS FOR TESTES/PROCEDURES MUST INCLUDE THE DIAGNOSIS/ MEDICAL REASON FOR THE TEST. **THIS MUST BE IN ICD10 DIAGNOSIS CODE.**

CIRCLE PROCEDURE	**Location/Dept. NW Pulmonary Lab**		**ICD-10**	**Diagnosis**
1	Spirometry- No bronchodilator			
2 2a	Pre/ Post bronchodilator as indicated by results according to ACH PFT Guidelines **(and order the bronchodilator in 2a below)** Albuterol 90 mcg INH _____ puffs inhaled with spacer once [Recommended procedure dose for testing: 4 puffs]			
3 3a.	Pre / Post bronchodilator for any results obtained **(and order the brochodilator in 3a below)** Albuterol 90 mcg INH _____ Puffs inhaled, with spacer once [Recommended procedure dose for testing: 4 puffs]			
4	Other Testing Needed_____			

Source Document Name: _____ Date of Document:_____

Scribed/ Transcribed for: _____ By_____ Title_____

ORDERING PHYSICIAN/ APRN PRINTED: _____ Time_____ Date_____

Physician/ APRN Signature: _____ Printed Name_____ Date_____ Time_____

The above signed Physician/ APN Certifies that the ordered tests/ procedures are medically necessary for the diagnosis and treatment of the patient. I am responsible for the care of the patient.

Contact Person: **Fax Results #:** **Phone Results #:**

Please fax this form directly to the specified service:

ARKANSAS CHILDREN'S NORTHWEST- FAX (479) 725-6582