Penn Medicine
Chester County Hospital

Pulmonary Function Lab
701 East Marshall St.
West Chester, PA 19380
610-431-5406

PULMONARY FUNCTION TESTS ORDER FORM

Physician must fax this form to 610-738-2625. A staff member will call patient to schedule testing.

Patient Name: ______________________________________ Date of Birth: _________________________

Patient's Phone Number: _____________________________ Diagnosis Code: _______________________

Ordering Physician: _______________________________________ Order Date: ______________________

Copy to: ____

**** NOTE: PLEASE DO NOT TAKE ANY BREATHING MEDICINES 6-8 HOURS PRIOR TO YOUR TEST ****

_____ **PFT** (Spirometry pre & post bronchodilator, Lung Volumes, Diffusion Capacity, RAW, GAW)

_____ **PFT** (Spirometry w/o bronchodilator, Lung Volumes, Diffusion Capacity, RAW, GAW)

_____ **Spirometry** (Forced Vital Capacity, Flow volume loop)

_____ **Spirometry Pre & Post Bronchodilator** (FVC, FVL, bronchodilator)

_____ **Lung Volumes** (TLC, VC, IC, FRC, ERV, RV, VTG, RAW, GAW)

_____ **Diffusion Capacity** (DLCO, DLCO/VA), must be ordered with Spirometry or Lung Volumes

_____ **Bronchial Challenge / Provocation** (Methacholine) Bronchial Provocation

_____ **MIP / MEP** (Maximum inspiratory and expiratory pressures)

_____ **ABG / Arterial Blood Gas** _____ ***Room Air*** _____ ***On Oxygen***

_____ **Oxygen Saturation** (HR, SpO_2) _____ ***Room Air*** _____ ***On Oxygen***

_____ **Six Minute Walk Test** (HR, SpO_2 with ambulation) _____ ***Room Air*** _____ ***On Oxygen***

_____ **Cardio-Pulmonary Exercise Stress Test** (Oxygen consumption and Carbon Dioxide Production).

Please bring a list of all medicines that you are currently taking. Arrive 15 minutes prior to your scheduled appointment to register. Bring this ***prescription form, insurance card and photo ID*** *with you.*

Physician Signature: ______________________________________ Date: ____________ Time: ____________