

NON-INVASIVE SERVICES ORDER FORM

PATIENT NAME (Last, First, Middle) _____	Social Security #: _____	Date of Birth: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Physician Signature: _____ Telephone: _____	Skilled Nursing Patient: Facility: _____	<input type="checkbox"/> Fax results to: _____	Date of Test: _____

PROVIDE DIAGNOSIS/SYMPTOMS FOR ALL TESTS ORDERED:

1) _____ 2) _____ 3) _____ 4) _____

Medicare does not generally cover routine screening tests.

(ALL TEST ARE PERFORMED IN ROOM 340)

INSTRUCTIONS (PULMONARY FUNCTION TEST):

1. CALL 978-521-8655 TO SCHEDULE TEST
2. FAX THIS FORM TO 978-521-8656
3. INSTRUCT PATIENT NOT TO TAKE BRONCHIODIALTOR FOUR HOURS PRIOR TO TEST.
4. INSTRUCT PATIENT TO REPORT TO REGISTRATION PRIOR TO TEST

INSTRUCTIONS (EEG):

1. CALL 978-521-8655 TO SCHEDULE TEST
2. FAX THIS FORM TO 978-521-8656
3. EEG ARE PERFORMED MONDAYS ONLY (7:30 A.M.; 8:30 A.M.; & 9:30 A.M.)
4. INSTRUCT PATIENT TO REPORT TO REGISTRATION PRIOR TO TEST

INSTRUCTIONS FOR EMG:

1. CALL 978-687-2321 TO SCHEDULE TEST
2. ASK TO SPEAK WITH DR. FINKLEMAN'S OFFICE
3. SCHEDULING WILL BE DONE THROUGH DR. FINKLEMAN'S OFFICE

<input type="checkbox"/> PFT COMPLETE	<input type="checkbox"/> PFT SCREEN	OTHER (CHECK ALL THAT APPLY)
FVC - FORCED VITAL CAPACITY	FVC - FORCED VITAL CAPACITY	<input type="checkbox"/> FVC - FORCED VITAL CAPACITY
FRC - FUNCTIONAL RESIDUAL CAPACITY	SVC - SLOW VITAL CAPACITY	<input type="checkbox"/> FRC - FUNCTIONAL RESIDUAL CAPACITY
DLCO - DIFFUSION CAPACITY		<input type="checkbox"/> DLCO - DIFFUSION CAPACITY
POST-BRONCHIODIALTOR (ALBUTEROL 2.5 MG/3ML SALINE)		<input type="checkbox"/> MVV - MAXIUM VOLUNTAR VENTILATION
POST-BRONCHIODIALTOR (OTHER _____)		<input type="checkbox"/> POST-BRONCHIODIALTOR (ALBUTEROL 2.5 MG/3ML SALINE)
		<input type="checkbox"/> POST-BRONCHIODIALTOR (OTHER _____)
		<input type="checkbox"/> ABG - ARTERIAL BLOOD GAS
		<input type="checkbox"/> EEG
		<input type="checkbox"/> EMG