



REQUEST FOR RESPIRATORY SERVICES

Date: _____ Facility: _____

Patient Name: _____ DOB: _____ Rm No: _____

Primary Diagnosis: _____

Cardio-respiratory Diagnosis: _____

Please check the box(es) for the indication(s) below for the Respiratory Therapy Consult:

- | | |
|--|---|
| <input type="checkbox"/> Diagnosis of Cardiopulmonary Disease | <input type="checkbox"/> Shortness of Breath noted at rest, on exertion or lying supine |
| <input type="checkbox"/> Exacerbation of Cardiopulmonary Disease | <input type="checkbox"/> Dyspnea with anxiety |
| <input type="checkbox"/> History and/or diagnosis of Pneumonia | <input type="checkbox"/> Change in baseline condition |
| <input type="checkbox"/> Recent history of mechanical ventilator use | <input type="checkbox"/> Abnormal lung sounds |
| <input type="checkbox"/> Recent history of BIPAP/BiLevel use | <input type="checkbox"/> Impaired Mucus Clearance |
| <input type="checkbox"/> Recent abdominal/thoracic surgery | <input type="checkbox"/> Oxygenation impairment |
| <input type="checkbox"/> Presence of a tracheostomy | <input type="checkbox"/> Ventilation impairment |
| <input type="checkbox"/> O2 order upon admission of > 5 LPM | <input type="checkbox"/> Tracheostomy Weaning |
| <input type="checkbox"/> Other: _____ | |

Initial RT Request(s):

- | | |
|--|---|
| <input type="checkbox"/> Assess and Recommend Respiratory Plan of Care | <input type="checkbox"/> VEST Therapy Evaluation |
| <input type="checkbox"/> CHF Risk Protocol Evaluation | <input type="checkbox"/> Pneumonia Risk Protocol Evaluation |

(Completed By-Print name/Discipline)

(Date)