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:

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

☐ Other: _____

Initial RT Request(s):

- ☐ Assess and Recommend Respiratory Plan of Care
- ☐ CHF Risk Protocol Evaluation
- ☐ VEST Therapy Evaluation
- ☐ Pneumonia Risk Protocol Evaluation

_____ _____

(Completed By-Print name/Discipline) (Date)