



## La Plata Medical Examiners

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[scheduling@lpmedx.com](mailto:scheduling@lpmedx.com)  
[impairments@lpmedx.com](mailto:impairments@lpmedx.com)

Date: 08/25/2025

The patient, John Smith

has been REFERRED TO:

Desert Pulmonary Rehab & Diagnostics

2675 S. Jones Blvd Ste 113

Las Vegas, NV 89146

Referred by: Damon Kalcich, DO

### **ORDERS FOR TESTING:**

#### **6-Min Walk Test - Please document distance in meters or feet.**

#### **Instructions:**

No bronchodilators 12 hour prior to test. Please do this prior to the Pulmonary Function Test

**\*\*Please forward completed report if the PFT meets ATS standards\*\***

- 6 MWT should meet ATS standards
- If the claimant uses oxygen, keep oxygen at standard flow rate
- Use an indoor hallway 30 meters long (100 feet required) with turnaround points marked with cones and starting point taped off.
- Patients should use their normal cane or walker
- Rest for 10 minutes before starting test. Lean on the wall during test if needed.
- Record SpO2 at each minute without stopping
- Record Borg scale at each minute
- Record distance in meters or feet
- This test must be done at a standardized facility like a hospital or pulmonary lab

#### **Pulmonary Function Test with DLCO & pre and post bronchodilators**

CPT Code 94729

CPT Code 94060

**DX:** Silicosis (J62.8)

**\*Please include post reading even if pre-values are above 80%**

Patient Name and information:

Name: John Smith

Phone number: 555.123.4567

DOB: 05/15/1970

Case ID: ABC123

Address: 123 Main Street, Anytown, NY 12345

\*Primary Insurance\*

Energy Employees OCCUP, Program

PO BOX 8304

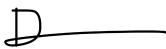
London, KY 40742-8302

866-272-8302

INSURED: John Smith

Plan/Program ENERGY EMPLOYEES OCCUP>PROGRAM, Group#, Insured ID# ABC123

Copay: \$0.00



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Damon Kalcich, DO  
La Plata Medical Examiners  
NPI #1558571851

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**\*Please fill out and FAX back to 505-675-2788\***

Name: \_\_\_\_\_

Predicted HR Max (22-Age) \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_

Medications: \_\_\_\_\_

### WALK 1

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Bronchodilator/time since last dose: \_\_\_\_\_

BP: _____		Supplemental OX: _____		Gait Aid: _____	
Time/Mins	SpO2	HR	Dyspnea	Rests	
Rest					
1					
2					
3					
4					
5					
6					
Recovery 1					
2					

\*\*Distance: \_\_\_\_\_

Limiting factor to the test:

SOB      Low SpO2 ☐      Leg Fatigue ☐      Other: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_