NHH
Northumberland Hills Hospital

Outpatient Pulmonary Function Requisition

Affix Patient Label.

Please do not write in this area.

Referral Date: _____

Booking Priority: ☐ Urgent ☐ Next Available

☐ Book in: _____

Referring Physician: _____
(please print)

Reason for Referral: _____

Existing Diagnosis: _____

Hgb Level (done within past 3 months): _____

Completed form to be faxed to
NHH Lab 905-373-6912

Patient name: _____

Address: _____

Telephone #: _____

Date of Birth: _____ Gender at Birth: _____

Height (cm): _____ Weight (kg): _____

Health card #: _____ VC _____

TESTING REQUIRED

☐ Hold inhalers   ☐ Do not hold inhalers

1. **Complete Pulmonary Function Test** ☐
   (flow-volume loop, pre & post bronchodilator, lung diffusion capacity, lung volumes, resting oximetry)

2. **Spirometry** ☐

3. **Pre/Post Bronchodilator Spirometry** ☐

4. **Lung Volumes & Airway Resistance** ☐

5. **Diffusion Capacity** ☐

6. **MIPS/MEPS** ☐

7. **Arterial Blood Gases** ☐
   ☐ On room air   ☐ On O2 _____ L/min

8. **Home Oxygen Assessment** ☐
   (Includes ABG on room air if resting SpO2 <91% and independent exertional assessment (IEA) if PaO2 does not qualify patient)
   ☐ For initial O2 funding
   ☐ For O2 funding re-qualification
   Funding renewal date: _____

9. **6 Minute Walk Test** ☐
   ☐ On room air   ☐ On O2 _____ L/min

Respiratory Medications

_____
_____
_____
_____
_____

Additional Comments

_____
_____
_____
_____
_____

_____
Ordering Provider's Signature

_____
Ordering Provider's Name (Please print)

_____
Fax Number