



NHH

Northumberland
Hills Hospital

Affix Patient Label.

Please do not write in this area.

Outpatient Pulmonary Function Requisition

<p>Referral Date: _____</p> <p>Booking Priority: <input type="checkbox"/> Urgent <input type="checkbox"/> Next Available</p> <p><input type="checkbox"/> Book in: _____</p> <p>Referring Physician: _____ (please print)</p> <p>Reason for Referral: _____</p> <p>Existing Diagnosis: _____</p> <p>Hgb Level (done within past 3 months): _____</p>	<p style="text-align: center;">Completed form to be faxed to NHH Lab 905-373-6912</p> <p>Patient name: _____</p> <p>Address: _____</p> <p>Telephone #: _____</p> <p>Date of Birth: _____ Gender at Birth: _____</p> <p>Height (cm): _____ Weight (kg): _____</p> <p>Health card #: _____ VC _____</p>
<p><u>Respiratory Medications:</u></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Please note: PFT may be postponed if a patient has had eye surgery or a myocardial infarction within 4-6 weeks prior to their scheduled appointment</p>	<p>TESTING REQUIRED</p> <p><input type="checkbox"/> Hold inhalers <input type="checkbox"/> Do not hold inhalers</p> <p>1. Complete Pulmonary Function Test <input type="checkbox"/> <i>(flow-volume loop, pre & post bronchodilator, lung diffusion capacity, lung volumes, resting oximetry)</i></p> <p>2. Spirometry <input type="checkbox"/></p> <p>3. Pre/Post Bronchodilator Spirometry <input type="checkbox"/></p> <p>4. Lung Volumes & Airway Resistance <input type="checkbox"/></p> <p>5. Diffusion Capacity <input type="checkbox"/></p> <p>6. MIPS/MEPS <input type="checkbox"/></p> <p>7. Arterial Blood Gases <input type="checkbox"/> <input type="checkbox"/> On room air <input type="checkbox"/> On O2 _____ L/min</p> <p>8. Home Oxygen Assessment <input type="checkbox"/> <i>(Includes ABG on room air if resting SpO2 <91% and independent exertional assessment (IEA) if PaO2 does not qualify patient)</i> <input type="checkbox"/> For initial O2 funding <input type="checkbox"/> For O2 funding re-qualification Funding renewal date: _____</p> <p>9. 6 Minute Walk Test <input type="checkbox"/> <input type="checkbox"/> On room air <input type="checkbox"/> On O2 _____ L/min</p>
<p style="text-align: center;">_____ Physician Signature</p> <p style="text-align: center;">_____ Fax Number</p>	