G.REFGBGH

Hôpital général de la baie Georgienne
GEORGIAN BAY
General Hospital

Appointment Date/Time:

_____

Pulmonary Function Test Requisition

Department of Respiratory Therapy
Georgian Bay General Hospital
Tel. (705) 526-1300 Ext. 5090
Fax. (705) 526-7837

Patient Information

Name:_____

DOB (dd/mm/yy): _____

Health Card Number: _____

Address: _____

_____

Postal Code: _____

Section 1: To be completed by the referring physician:

Diagnosis/History: _____

Reason for Testing: _____

Medications/Inhalers: _____

Section 2: Check Tests Required

☐ Complete Pulmonary Function Test
(Spirometry, lung volumes, DLCO, bronchodilator response with salbutamol)

☐ Oxygen Saturation at Rest

☐ Pre Spirometry *(hold puffers for 12 hours)*

☐ Post Spirometry *(hold puffers for 12 hours)*

☐ Lung Volume Measurement only

☐ Diffusion Capacity Measurement only

☐ Airway Resistance

Section 3: Special Procedures

☐ 6 Minute Walk Test (with Distance)

☐ Home Oxygen Program (HOP) Exercise Oximetry

☐ Initial ☐ Renewal

**Single-blind Air/Oxygen resting and exercise oximetry for MOHLTC home oxygen funding*

☐ Arterial Blood Gas on Room Air

☐ Arterial Blood Gas on Oxygen _____L/min

☐ Maximal Inspiratory & Expiratory Pressures (MIPS/MEPS)

Section 4: Physician Information

Referring MD:	Family MD:
Telephone Number	Fax Number
Physician Signature	Billing #