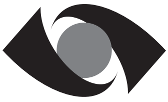

Medical Arts Building
581 Davis Drive, 5th floor Suite 513
Newmarket, ON L3Y 2P6

Respiratory Therapy Department

Health Record #: ____________ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* ____________
DOB: dd / mm / yy Age: ______ ❑ Female ❑ Male
OHIP #: ____________ Version Code: ____________
Account #: ____________ Date of Admission: dd / mm / yy

Pulmonary Function Requisition

Referring Physician Name: *(print first, last)*

Additional Reports to:

Diagnosis:

❑ **Full PFT** **OR** ❑ Flow-Volume Loop ❑ Check if bronchodilator **NOT** desired
❑ Diffusing Capacity ❑ Supine Flow Volume Loop
❑ Lung Volumes ❑ MIP/MEP

Symptoms: ❑ Cough ❑ Wheezing ❑ Dyspnea ❑ Effort intolerance
Smoker: ❑ No ❑ Yes ______ packs/day for ______ years
❑ Ex-smoker - quit for ______ years - was ______ packs/day for ______ years
Medications: ❑ Bronchodilators ❑ Steroids ❑ Beta blockers

Other Tests:
❑ bronchial provocation *(Methacholine Challenge) – must have flow-volume loop + bronchodilator done first*
❑ 6 minute walk test *(cannot be used to qualify patient for home oxygen, use IEA below)*
❑ air hypoxia study – patient must by flying within the next 3 months
❑ shunt study
❑ ABG's (arterial blood gases) – for home 0_2 assessment or pre-op ❑ independant exercise assessment (IEA) for home oxygen
Do on Room Air ____________ on 0_2 ________
Should test indicate qualification for Home Oxygen, arrangement for oxygen set up may be made unless otherwise indicated.
❑ **No Home Oxygen set up without order from attending physician**

$Fi0_2$	pH	PCO_2	PO_2	HCO_3	Be	0_2 Sat	**Physician's Signature**

Bronchodialation given according to medical directives BI-Rt by: *(print first, last)* ____________

Test Date: dd / mm / yy by: *(print first, last)* ____________ **Signature:** ____________ **RRT**

Progress Notes: ____________

____

____

____

By: *(print first, last)* ____________ **Signature:** ____________ **Date:** dd / mm / yy

- *Please complete and send this form to the Respiratory Therapy Department.* ***Fax #: 905-952-2462****. Patients* ***must not*** *take short acting bronchodilators for four hours prior to testing and long acting bronchodilators for twelve hours.*
- *Patients to arrive 15 minutes early to register.*
- *To cancel or change appointment, please call patient scheduling at 905-895-4521, ext. 2665.*