

PULMONARY FUNCTION REFERRAL FORM

PATIENT INFORMATION		REFERRING PHYSICIAN INFORMATION	
Name:		Physician:	
PHN:	DOB:	PracID:	
Address:		Clinic Information:	
City/Province/Postal Code:		Address:	
Phone:		Phone:	Fax:
Email:		Physician Signature	

REASON FOR REFERRAL		<input type="checkbox"/> URGENT REFERRAL
<input type="checkbox"/> Asthma <input checked="" type="checkbox"/> Screen <input checked="" type="checkbox"/> Evaluation	<input type="checkbox"/> Chest Pain	Other:
<input type="checkbox"/> COPD <input checked="" type="checkbox"/> Screen <input checked="" type="checkbox"/> Evaluation	<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Smoker: <input checked="" type="checkbox"/> Current <input checked="" type="checkbox"/> Former	<input type="checkbox"/> Abnormal CXR / CT	
<input type="checkbox"/> Cough	<input type="checkbox"/> Interstitial Lung Disease	
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Pre-Surgery	
<input type="checkbox"/> Shortness of breath with exertion	<input type="checkbox"/> Annual Referral	

PULMONARY FUNCTION TESTING REQUEST
<input type="checkbox"/> Spirometry - Includes bronchodilator response testing
<input type="checkbox"/> Pulmonary Function Testing – Diffusion Capacity, Lung Volumes by Plethysmography, Bronchodilator
<input type="checkbox"/> Spirometry and Diffusion Capacity – Includes bronchodilator response testing
<input type="checkbox"/> Other (please specify):
Please check mark if patient is NOT to withhold current inhalers (ie. testing new inhaler treatment response) <input type="checkbox"/>

HISTORY / COMMENTS

MEDICATIONS

SPECIAL NEEDS
<input type="checkbox"/> Interpreter needed <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Mobility limitations

PLEASE FAX TO ASPIRE LUNG LAB AT FAX: 780-761-3225, WE WILL CONTACT THE PATIENT DIRECTLY TO BOOK APPT