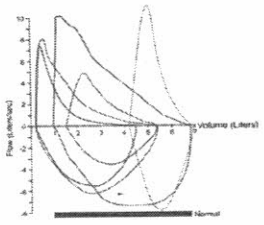

Respiratory Services LTD.
Toronto Lung Clinic

LF 20, 1849 Yonge Street, Toronto, Ontario, M4S 1Y2
Tel: 416-920-3737 Fax: 416-920-7848

PULMONARY FUNCTION TESTS REQUISITION

Date: _____

Patient Name: _____

Address: _____

Telephone #: _____ **Cell:** _____

Work Phone: _____

DOB: _____

OHIP / VC: _____

Clinical Inforation: ☐ **Dyspnea** ☐ **Sputum** ☐ **Cough** ☐ **Smoker** ☐ **Asthma**

☐ **COPD** ☐ **Pre-op** ☐ **Occupational Assessment** ☐ **Other:** _____

Tests Required: (Check all that apply)

☐ Complete Pulmonary Functions (Includes spirometry, lung volumes, diffusing capacity)
Post bronchodilator testing will be automatic, if not required, please indicate: ☐ No

☐ Arterial Blood Gases ☐ Room Air or ☐ Oxygen @ _____ L/min

☐ Asthma Assessment
- If asthma suspected, do you want bronchodilator given? ☐ Yes ☐ No
- If asthma suspected and there is no bronchodilator response, do you want a Methacholine Challenge? ☐ Yes ☐ No

☐ Six minute walk test

☐ Special Test (s): _____
(Exercise testing, Exercise asthma assessment, Exercise disability evaluation)

A Respirologist must be consulted if you require either of the following:

☐ Progessive Excercise Test

☐ Exercise asthma assessment

Printed Physician's Name: _____ Physician's billing number: _____

Physician's Signature: _____