St. Joseph's Healthcare Hamilton

PULMONARY FUNCTION REQUISITION

Name: D.O.B.:
Address: HC No.:
City & Postal Code:
Legal Guardian: Full Name and contact number(s):

Phone #:
Copies to:

Firestone Institute for Respiratory Health
St. Joseph's Healthcare Hamilton
Charlton Campus, Juravinski Tower, Level 1
50 Charlton Ave East, Hamilton, ON L8N 4A6
Tel: 905.521.6000 Fax: 905.523.LUNG (5864)

Appointment Booking, please call 905-521-6000 or Fax: 905.523.LUNG (5864)

Appt. Date (yyyy/mm/dd) & Time (hh:mm): _____

Clinical Problems: _____

Reason for Test(s): _____

Medications (Respiratory & Cardiac): _____
(Ask patient to bring in all medicines)

Haemoglobin (Most recent for correction of single breath D_LCO): _____ g/L; Date measured: _____

Active Communicable Disease: No: _____ Yes: _____ Specify: _____

( ) **Flow Volume Curves** (Spirometric values derived from a flow volume curve including FEV1, VC & Flow Rates)

( ) **Repeat Flow Volume Curves** post bronchodilator

( ) **Skin Prick Test to Common Allergens** **(No antihistamines for 4 days)**

( ) **Pulmonary function** (flow volume curves, lung volumes, single breath D_LCO, airways resistance, maximal inspiratory / expiratory pressure, oximetry if indicated)

( ) **Repeat flow volume curve post bronchodilator**

( ) **Exercise test** (progressive work on bicycle, flow volume curve, ECG, BP, heart rate & ventilation, VO2, VCO2, Oximetry)

( ) **Independent Exercise Assessment.** FiO_2/Flow Rate (Lpm) _____

( ) **6 Minute Walk Test on Room Air** (otherwise specify oxygen requirements); _____

( ) **Provocholine Challenge** (to assess bronchial hyper-responsiveness)

( ) **Arterial Blood Gases** FiO_2 _____

Anticoagulants: No: _____ Yes: _____ Specify: _____

( ) **Sputum induction** (inhalation of hypertonic saline) for:
( ) Differential Cell Count ( ) Other _____

( ) **Specific allergen skin test** (ie Food, Latex) please specify; _____

( ) **Other,** please specify; _____

Physician's Printed Name: _____ Fax number: _____

Physician's Signature: _____ CPSO#: _____ Date signed: _____
(yyyy/mm/dd)