Sunnybrook Health Sciences Centre
Pulmonary Function Laboratory
D-Wing, 6th/Floor, Rm D670
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Date (YY/MM/DD)

REQUISITION FOR PULMONARY FUNCTION TESTS (PFTs)

BRADMA

PATIENT INFORMATION ***(Please print)*** Health Card Number:_____ Version code:_____

Name (First, Last):_____ Date of Birth: (yyyy):_____(mm):_____(dd):_____

Address:_____City:_____Prov.:_____ Postal Code:_____

Phone: Day ( ) _____ - _____ Phone: Evening ( ) _____ - _____ Email:_____

Please check ONE only: ☐ SHSC Out-Patient Clinic MRN:_____ ☐ SHSC In-Patient ☐ Private Out-Patient

Appointment Date:_____ Time:_____A.M./P.M.

REFERRING PHYSICIAN ***(Please Print)*** SHSC Out-Patient Clinic:_____

Name (First, Last):_____ Phone: ( )_____ - _____ Fax: ( )_____ - _____

Address:_____City:_____Prov.:_____ Postal Code:_____

CLINICAL INFORMATION (*If any in the line below checked, recommend postponing PFTs*)

☐ MI less than 3 months ago ☐ Unstable Angina ☐ Suspect active TB ☐ Hemoptysis ☐ Eye surgery less than 4 weeks ago

Diagnosis:_____ Hb:_____ g/L Date (yy/mm/dd):___ /___ /___

☐ Non-smoker ☐ Smoker or Ex-Smoker:_____ pack years _____ years quit

Respiratory Medications:_____

ADDITIONAL INFORMATION

If previous PFTs, ☐ Sunnybrook or ☐ Specify:_____ Do not mail report, but fax to:_____

INDICATION/REASON FOR TEST

☐ Diagnosis ☐ Pre-operative ☐ Baseline ☐ Comparison ☐ Compensation ☐ Specify:_____

TEST(S) REQUESTED (*Note: In order to obtain reliable results, patient must be able to follow verbal instructions*)

☐ Spirometry ☐ Diffusing Capacity ☐ Lung Volumes

☐ All of the ABOVE (Routine PFTs) ***with*** ☐ **Bronchodilator Response ***and*** ☐ Oxygen Saturation at Rest

☐ Maximum Inspiratory/Expiratory Pressures ***or*** ☐ SNIP ☐ Supine Spirometry ☐ Peak Cough Flow

☐ **Methacholine Challenge **and** Routine PFTs

☐ Exercise Studies

(i) ☐ **Exercise-Induced Bronchoconstriction (*Cannot be done with Methacholine Challenge on the same day*)

(ii) ☐ Exercise Oximetry for MoH Home O_2 Program (*To qualify for home O_2 when Arterial Blood Gas is not possible*)

(iii) ☐ 6-Minute Walk Test ☐ On O_2 at _____ L/min or _____ % F_IO_2 (*Restricted to Respirology ONLY*)

(iv) ☐ Oxygen Titration at Rest and Exercise (*To assess flow rate needed for patients already on home O_2*)

☐ Overnight Oximetry (*In-Patient ONLY*)

***Special patient instruction to withhold certain medications is required. Please see <u>REVERSE</u>.*

Physician Name (*please print*) and Signature:_____