



HPHA Cardiorespiratory Requisition

Fax: (519) 272-8201

Phone: (519)272-8210 x 2415

Affix Patient Label

**PULMONARY FUNCTION TEST REQUISITION. PLEASE FAX to 519-272-8201
ALL SECTIONS ON PAGE 1 & 2 MUST BE COMPLETED AND SIGNED**

<u>Patient Information</u>	<u>Referring Practitioner Information</u>
Last Name: _____	Name: _____
First Name: _____	Phone: _____
Health Card #: _____	Fax: _____
Date of Birth: _____	
Gender: _____	
Phone: _____	
Family Doctor: _____	
Diagnosis: _____	Patient is positive for: <input type="checkbox"/> ARO <input type="checkbox"/> VRE <input type="checkbox"/> MRSA <input type="checkbox"/> C-Diff

Choose ONLY ONE test:	<input type="checkbox"/> Screening for COPD (Note: Bronchodilator will only be given if Fev1/FVC less than LLN) <i>*Withhold bronchodilators – please refer to chart on second page for required withhold times</i>
	<input type="checkbox"/> Screening for Asthma (Pre/post bronchodilator spirometry) <i>*Withhold bronchodilators – please refer to chart on second page for required withhold times</i>
	<input type="checkbox"/> Paediatrics – Spirometry <i>*For patients 6 years of age or older</i>
	<input type="checkbox"/> Asthma or COPD Follow up (Spirometry only)
	<input type="checkbox"/> Shortness of breath NYD/ Chronic cough/ Interstitial Lung Disease (Full pulmonary function testing)
	<input type="checkbox"/> Methacholine Challenge <i>*For patients 16 years of age or older. Must have prior spirometry (please include).</i>
	<input type="checkbox"/> Exercise Induced Asthma <i>*For patients 10 years old or older -. Must have prior spirometry (please include).</i>
	<input type="checkbox"/> Hypoxemia on Exertion (Requires Internal Medicine Consult)
Additional Testing:	<input type="checkbox"/> Blood Gas Sampling <input type="checkbox"/> Arterial <input type="checkbox"/> Room Air <input type="checkbox"/> With O2

- CONTRAINDICATIONS:**
- Surgery within past 4 weeks
 - Recent heart attack or stroke
 - Uncontrolled/untreated aneurysm
 - TB or Active infection

If questions about the most appropriate test or age cut-offs call: 519-272-8210. Ex 2200



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Patient missed or cancelled appointment. If testing is still required, please send **NEW** requisition.

If you have referred your patient for a Pre/Post Test, see the list below to determine if your patient may stop their medication for the required time before their appointment. **Failure to complete this section will result in the inability to schedule this appointment.**

**Please check the box to indicate if the patient is currently not taking medication.*

No respiratory medications in use

**Please check boxes next to medications to indicate which medications the patient is currently taking.*

	MEDICATION	HOURS WITHHELD		MEDICATION	HOURS WITHHELD		MEDICATION	HOURS WITHHELD
	ACCOLATE	0		FLOVENT	0		SINGULAIR	0
	ADVAIR	24		FORADIL	24		SPIRIVA	48
	AIROMIR	6		FORMOTEROL	24		SYMBICORT	24
	ALVESCO	0		INCRUSE	48		TERBUTALINE	6
	ANORO	48		INSPIOLTO	48		TIOTROPIUM	48
	ARNUITY	0		MONTELUKAST	0		TORNALATE	6
	ASMANEX	0		ONBREZ	48		TRELEGY	48
	ATECTURA	48		OXEZE	24		TUDORZA	48
	ATROVENT	12		PULMICORT	0		ULTIBRO	48
	BREO	48		QVAR	0		VENTOLIN	6
	BREZTRI	48		SALBUTAMOL	6		WIXELA	24
	BRICANYL	6		SALMETEROL	24		ZAFIRLUKAST	0
	COMBIVENT	12		SALVENT	6		ZENHALE	24
	DUAKLIR	48		SEEBRI	48			
	ENERZAIR	48		SEREVENT	24			

I have reviewed the information above and advised my patient to hold, if required, or continue their medication as usual.

Physician signature: _____

Date: _____