niagarahealth
Extraordinary Caring. Every Person. Every Time.

Pulmonary Function Consultation Requisition

INCOMPLETE REQUISITIONS WILL BE RETURNED

PLEASE SELECT PATIENT'S PREFERRED SITE FOR EXAMINATION(S) AND FAX ALL COMPLETED REFERRAL FORMS TO:

☐ **Earliest available appointment (No site preference)**	☐ **St. Catharines Site 1200 Fourth Ave St Catharines**	☐ **Niagara Falls Site 5685 North St Niagara Falls**	☐ **Welland Site 65 Third St. Welland**
Fax: 289-398-1060			**Phone: 289-378-4647 ext. 44187**

Please PRINT information below. Please do not imprint.

Surname		First Name	
Home Address			Postal Code
D.O.B. (dd/mm/yyyy)	Sex	H.C.N and Version	
Telephone		Alternate Contact Number	
Referring Physician (Include Initials)		City	
Referring Physician Telephone			

PLEASE CHECK THE APPROPRIATE EXAMINATION(S) AND DOCUMENT THE INDICATIONS FOR EACH EXAMINATION REQUESTED

☐ Spirometry only	☐ Full Pulmonary Function Test
☐ Arterial Blood Gases (ABGs) Please specify 02 concentration _____ Room Air _____ LPM Oxygen	☐ CPET (ordered by Respirologist only and **only available at SCS**)
☐ 6 Minute Walk Test (MWT) (Not for home O2 qualifications)	☐ Home oxygen assessment/ I.E.A. (Blinded Walk Test) *If resting SpO2 ≤ 90% perform ABG
☐ Methacholine Challenge Test	☐ Skin Allergy Test **(Only available at SCS)**

INDICATIONS

Referring Physician Signature: _____