niagarahealth

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Pulmonary Function Consultation Requisition

PLEASE FAX ALL COMPLETED REFERRAL FORMS TO: **INCOMPLETE REQUISITIONS WILL BE RETURNED**

Welland Hospital Site:	St. Catharines Site	Greater Niagara General Site
905-732-9537	289-398-1060	905-358-7438
Booking Office Contact:	Booking Office Contact:	Booking Office Contact:
905-378-4647 ext. 32278	905-378-4647 ext. 44187	905-378-4647 ext. 54947

Please PRINT information below. Please do not imprint.

Surname		First Name
D.O.B. (dd/mm/yy)	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: _____