Brockville General Hospital

Respiratory Therapy Services
Pulmonary Function Requisition
Fax: 613-345-8342

INSTRUCTIONS FOR REFERRAL

1. Please ensure the below referral form is completed, patient information provided to patient, and any supporting documentation attached.
2. Please fax referral to Respiratory Therapy Services at 613-345-8342

NOTE: Incomplete referrals will be returned by fax and not processed until complete.

Date of Referral (DD/MM/YYYY): _____

Referring Provider Information	
Referring Provider Name (please print): _____	
Referring Provider Contact Number: _____	
Referring Provider Fax Number: _____	
Patient Demographics	
☐M ☐F ☐N (N= Gender Neutral or choose not to disclose)	
Last Name: _____	First Name: _____
Health Card #/VC: _____	Date of Birth: (DD/MM/YYYY): _____
Contact Number: _____	Address: _____
City: _____	Postal Code: _____
Medical Information	
Precautions: ☐ MRSA ☐ C-Diff Other: _____	
Allergies: _____	
Code Status: ☐ Full Code ☐ DNR (DNR forms must be attached)	
Priority	
☐ Urgent (within 3 weeks) Reason_____ ☐ within 2 months ☐ Routine	
Indication for Testing	
☐ COPD ☐ Cough ☐ Pre-op (Surgery Date if known: _____)	
☐ Asthma ☐ ILD ☐ Transplant	
☐ Dyspnea ☐ Follow-up ☐ Other_____	
Pulmonary Function Testing	
☐ Spirometry pre bronchodilator ☐ Spirometry post bronchodilator (200-400 mcg salbutamol) ☐ Lung Volumes ☐ Diffusing capacity ☐ All of the above	☐ Methacholine Challenge study for diagnosing asthma when spirometry is not definitive. Spirometry with bronchodilator must have been completed within 3 months of challenge study
PLEASE NOTE: Patients having PFT for diagnostic assessments will be instructed to stop taking inhaled therapy for 24 -48 hours prior to testing.	
Special Procedures	
☐ Arterial blood gas ☐ Room air ☐ with oxygen _____ LPM ☐ Home oxygen assessment for MOH funding ☐ Pulse oximetry at rest ☐ with exertion ☐ Six minute walk test ☐ IEA independent exercise assessment for home oxygen funding. Single blind air\oxygen exertional oximetry ☐ MIP\MEP indicated for suspected respiratory muscle weakness	
Ordering Practitioner Signature:_____	
If requiring hard copy of results please identify by placing fax number here: _____	