INSPIRATION
Pulmonary Function Lab

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PULMONARY FUNCTION LAB TEST REQUISITION

All requisitions should be completed and sent to:

Inspiration Pulmonary Function
340 College St. 3rd Floor, Suite # 315,
Toronto, Ontario M5T 3A9
Tel: 416-944-9602 Fax: 416-944-1513
Email: inspirationpft@gmail.com

(PLACE STICKER BELOW)

Last Name: _____First Name: _____

Tel: _____Alt Tel: _____

DOB: _____Health Card #_____ VC: ____

Address: _____

Email: _____ Ref Physician: _____

☐ **ROUTINE PULMONARY FUNCTION STUDY** (includes all individual tests below)

OR

SELECT INDIVIDUAL TESTS BELOW

☐ Spirometry ☐ Spirometry after Bronchodilator ☐ Diffusion Capacity
☐ Lung Volumes ☐ O2 Saturation by Pulse Oximetry (at rest)

☐ **6 Minute Walk Test** ☐ on Room Air **OR** ☐ on O_2 at ____LPM Nasal Prongs
☐ Use patient's O2 device and current setting

☐ **6 Minute Walk Test (single blind Air/O2 assessment)** on O_2 at ____LPM Nasal Prongs

☐ **Fractional Exhaled Nitric Oxide (FeNO) Test** (*Non-OHIP fee of $70)

Optional Questionnaires: ☐ Asthma Control Test (ACT) ☐ Asthma Control Questionnaire ☐ COPD Assessment Test (CAT)
Smoking Status: ☐ Non-smoker ☐Former Smoker (____ pack/years) ☐ Current Smoker (____ pack/years)
Current Respiratory Medications: _____
Non-Respiratory Medications: _____
Provisional Diagnosis: _____

CLINICAL INFORMATION (required entry)		**REASON FOR TEST** (required entry)
Is there a contraindication to Bronchodilators?	☐ YES ☐ NO	_____
Recent Hemoptysis?	☐ YES ☐ NO	
Unstable Angina?	☐ YES ☐ NO	_____
Myocardial infarction previous 3 months?	☐ YES ☐ NO	_____
Possible TB (or other infections disease)?	☐ YES ☐ NO	
Eye surgery previous 4 weeks?	☐ YES ☐ NO	_____
Allergy to latex?	☐ YES ☐ NO	_____

PHYSICIAN NAME (print): _____BILLING #_____ | DATE: _____

PHYSICIAN Signature:_____ | TEL:_____ | FAX:_____

Appointment Test Date and Time:

***Non-OHIP fees can be paid with cash, credit, debit, Interac e-transfer, and Apple or Google Pay.**