PULMONARY FUNCTION LAB TEST REQUISITION

**All requisitions should be completed and sent to:**

**(PLACE STICKER BELOW)**

**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**

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 O2 at \_\_\_\_LPM Nasal Prongs

Use patient’s O2 device and current setting

**6 Minute** **Walk Test (single blind Air/O2 assessment)** on O2 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.**