Queen Elizabeth II
Health Sciences Centre
CAPITAL HEALTH

Patient Name/Identification:

Request for *Out-Patient* Pulmonary Function Tests

Ph: 473-4267 Fax: 473-6351

Patients Name:	Date of Birth:
Complete Mailing Address:	
Postal Code:	Phone:
Department of Health/ Provincial Medical Insurance Number:	

Pulmonary Function testing requires coordination and co-operation to ensure valid, usable data. Certain patients may be unable to tolerate / perform all tests.

REASON FOR TESTING: _____

___ SPIROMETRY (FVC, FEV_1) • *Bronchodilators will be administered if obstruction is present*

CLINICAL INFORMATION MUST BE PROVIDED TO JUSTIFY ADDITIONAL TESTS

____ METHACHOLINE CHALLENGE • *If indicated by previous spirometry results*

Additional tests available	**Reason**
____ LUNG VOLMES (SVC,FRC)	_____
____ DIFFUSING CAPACITY	_____
____ OXYGEN SATURATION	_____
OTHER (Specify): _____	_____

If there are other tests you require that are not listed here, indicate which one and why. Should you wish to discuss this further, please telephone the lab @ 473-4267.

Physicians Name: _____ Date: _____
(Please Print)

Phone _____ Fax: _____