



S0359

PULMONARY FUNCTION CONSULTATION

St. Joseph's Health Centre Phone Line: 416-530-6015
 East Wing, Room 1E-132 Fax Line: 416-530-6702
 30 The Queensway, Toronto ON Page 1 of 1

Name: _____
 Male ☐ Female ☐
 MRN : _____
 DOB: _____
 Address: _____
 Telephone: _____
 OHIP #: _____

INCOMPLETE FORMS WILL BE RETURNED AND NOT PROCESSED

☐ Urgent Outpatient (within 72 hours) ☐ Preoperative Patient

☐ **FULL PULMONARY FUNCTION TESTS (ADULTS*)** *For patient below minimum ages, please comment in Clinical History
Includes Spirometry/FVL (Bronchodilator administered if obstructed), Lung Volumes, Diffusion Capacity, SpO₂ at rest
☐ Diffusion Capacity only ☐ Lung Volumes/Plethysmography only ☐ Bronchodilator not to be given

OTHER PULMONARY FUNCTION TESTS (AGES 7+*) *This section will be ignored if Full PFT (above) is selected.*

☐ Spirometry only - via FVL (Flow Volume Loop) test ☐ Pre & Post Bronchodilator Spirometry only ☐ SpO₂

EXERCISE TESTING (Wear comfortable footwear) - Please select only one type of exercise test

☐ SpO₂ On Exertion ☐ Exercise Oxygen Assessment for Home Oxygen
☐ Six Minute Walk Test ☐ ABG and Exercise Oxygen Assessment for Home Oxygen

OTHER

☐ **Methacholine Challenge**
 Currently on Hold

☐ Arterial Blood Gas (ABG)
☐ Maximal Inspiratory/ Expiratory Pressure (MIP/MEP)

****Methacholine Challenge testing is NOT booked on the same day as Routine Pulmonary testing, recent PFT report required****

****Methacholine preparation:-**No short-acting bronchodilators 8 hours prior to test. No long-acting bronchodilators, steroids or antihistamines 48 hours prior to test. No anticholinergics/montelukast 24 hours prior to test. Test not done during pregnancy or while breastfeeding.

CLINICAL HISTORY/REASON FOR TEST

ADDITIONAL INFORMATION *Contact info. is optional, but please provide parent/guardian details for paediatric patients*

☐ Falls Risk ☐ Lifting Device Required ☐ Patient with Restraints (must be accompanied)

Does Patient Consent to Appointment Information Being Disclosed in a Telephone Message? ☐ Yes ☐ No

Able to Come in on Short Notice? ☐ Yes ☐ No Requires interpreter? ☐: Please Specify Language

Contact: Please Specify name, relation to patient, phone number and for MyChart: date of birth or OHIP#

E-mail: Can be patient's or contact's ☐ Contact's E-mail? Send MyChart invitation once this form is received? ☐ Yes (e-mail) ☐ Yes (SMS) ☐ No

REQUESTING PHYSICIAN

Address: _____ City: _____ Postal Code: _____

Telephone Number: _____ Fax: _____ CPSO/CNO#: _____

Copy to: _____ MD/NP (Copied Provider(s)' Name(s))

DATE/TIME

SIGNATURE

PRINT NAME

DD / Month / YYYY ____:____h