

Pulmonary Function Lab
 St. Joseph's Health Care London
 268 Grosvenor St, London, ON N6A 4V2
 Outpatient Registration: Room B3-030
 Zone B, Level 3
 Phone: 519 646-6000 ext. 61389, Fax: 519 646-6164



PULMONARY FUNCTION TEST REQUISITION. PLEASE FAX to 519 646-6164 ALL SECTIONS ON PAGE 1 & 2 MUST BE COMPLETED AND SIGNED TO BE TRIAGED	
<u>Patient Information</u>	<u>Referring Practitioner Information</u>
Last Name: _____	Name: _____
First Name: _____	Phone: _____
Health Card #: _____	Fax: _____
Date of Birth: _____	Signature: _____
Gender: _____	
Phone: _____	

Choose ONLY ONE test:	☐ Screening for COPD (Pre/post bronchodilator spirometry) <i>*Withhold bronchodilators – please refer to chart on second page for required withhold times</i>
	☐ Screening for Asthma (Pre/post bronchodilator spirometry) <i>*Withhold bronchodilators – please refer to chart on second page for required withhold times</i>
	☐ Asthma or COPD Follow up (Spirometry only)
	☐ Shortness of breath NYD/ Chronic cough/ Pre-op assessment/ Other (Full pulmonary function testing)
	☐ Interstitial Lung Disease (Full pulmonary function testing)
	☐ Other specific pulmonary function tests request not listed, please contact 519 646-6000 x61389 for assistance
CONTRAINDICATIONS: • Surgery within past 4 weeks • Recent heart attack or stroke • Uncontrolled/untreated aneurysm • TB or Active infection	

PFT Lab Use Only: Appointment: _____

☐ Patient missed or cancelled appointment. If testing is still required, please send **NEW** requisition.

If you have referred your patient for a Pre/Post Test, see the list below to determine if your patient may stop their medication for the required time before their appointment. **Failure to complete this section will result in the inability to schedule this appointment.**

****Please check the box to indicate if the patient is currently not taking medication.***

☐ No respiratory medications in use

****Please check boxes next to medications to indicate which medications the patient is currently taking.***

	MEDICATION	HOURS WITHHELD		MEDICATION	HOURS WITHHELD		MEDICATION	HOURS WITHHELD
	ACCOLATE	0		FLOVENT	0		SINGULAIR	0
	ADVAIR	24		FORADIL	24		SPIRIVA	48
	AIROMIR	6		FORMOTEROL	24		SYMBICORT	24
	ALVESCO	0		INCRUSE	48		TERBUTALINE	6
	ANORO	48		INSPIOLTO	48		TIOTROPIUM	48
	ARNUITY	0		MONTELUKAST	0		TORNALATE	6
	ASMANEX	0		ONBREZ	48		TRELEGY	48
	ATECTURA	48		OXEZE	24		TUDORZA	48
	ATROVENT	12		PULMICORT	0		ULTIBRO	48
	BREO	48		QVAR	0		VENTOLIN	6
	BREZTRI	48		SALBUTAMOL	6		WIXELA	24
	BRICANYL	6		SALMETEROL	24		ZAFIRLUKAST	0
	COMBIVENT	12		SALVENT	6		ZENHALE	24
	DUAKLIR	48		SEEBRI	48			
	ENERZAIR	48		SEREVENT	24			

I have reviewed the information above and advised my patient to hold, if required, or continue their medication as usual.

Physician
signature: _____

Date: _____