

PULMONARY HEALTH REFERRAL

Name: _____	Physician Name: _____
Address: _____	PRACID: _____
Phone: _____	Phone: _____
Date of Birth: _____	Fax: _____
Health Card #: _____	Signature: _____

REQUISITION FOR

- ☐ Pulmonary Consult (Includes all necessary Pulmonary Tests as directed by Respiriologist. Please include any relevant medical information in comments)
- ☐ Full Pulmonary Function Test
- ☐ Spirometry (Pre/Post)
- ☐ Arterial Blood Gas
- ☐ Methacholine Challenge Test
- ☐ Sleep Apnea Testing / Treatment (Level III Sleep Study [HSAT] Assessment, AutoCPAP Trial and Treatment, please add reason for referral in comments) *

REASON FOR REFERRAL

☐ Asthma	☐ COPD	☐ Dyspnea	☐ Cough
☐ ILD	☐ Screening	☐ Other: _____	

Comments: _____

Current Respiratory Medications: _____

All testing includes respiratory education, pathology education, device teaching, if applicable.

**Note: Sleep Services provided by Respiratory Dynamics Sleep Group*