NORTHERN
PULMONARY DIAGNOSTICS

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PULMONARY HEALTH REFERRAL

Name: _____ Physician Name: _____

Address: _____ PRACID: _____

Phone: _____ Phone: _____

Date of Birth: _____ Fax: _____

Health Card #: _____ Signature: _____

REQUISITION FOR

- ☐ Pulmonary Consult (In Person Consultation, includes all necessary Pulmonary Tests as directed by Respirologist. 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*