BULK BILLED LUNG FUNCTION REFERRAL

Dr Lydia Mowlem
General Medicine, Respiratory & Sleep Physician

PATIENT DETAILS

Name:_____ **DOB:**_____ **Phone:**_____

Address:_____

Email:_____ **Work:**_____

Medicare/DVA number:_____ **Ref:**_____ **Expiry:**_____

PLEASE NOTE: Please refrain from using inhalers, smoking and vigorous exercise 4hrs prior to testing, if possible.

CLINICAL HISTORY/DETAILS

☐ **Current Smoker** ☐ **Ex-smoker** ☐ **Non-smoker**

Clinical details:_____

_____

_____

_____

TESTS REQUIRED

- ☐ **Spirometry and DLCO Gas Transfer**
- ☐ **Full lung function (Spirometry, DLCO and Lung Volumes)**
- ☐ **Pre and Post Bronchodilator**
- ☐ **Consultation with Dr Lydia Mowlem, Respiratory Physician**

FOR THIS REFERRAL TO BE VALID, PLEASE ENSURE THE FOLLOWING DETAILS ARE COMPLETED

Referring Dr:_____ Provider No:_____

Practice Name:_____ Phone:_____

Email:_____Signature:_____

(07) 3283 7001
(07) 3319 6205
info@lmms.com.au
www.lmms.com.au

Suite 18, Peninsula Specialist Centre, 101 George Street, Kippa-Ring, 4021.