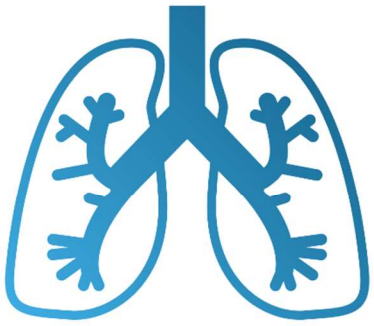

East Coast Respiratory and sleep

Adult and Paediatric Pulmonary Request Form

Patient Information:

Name: _____Date of Birth: __/__/__Gender: _____

Height: _____ Weight: _____ Phone: _____

Smoking history:_____Current inhalers:_____

Reason for Test: Please check all that apply:

[ ] Assessment of lung function prior to surgery

[ ] Evaluation of lung function in patients with respiratory symptoms (cough, wheezing, shortness of breath)

[ ] Assessment of lung function in patients with known lung disease (COPD, asthma, etc.)

[ ] Monitoring of lung function in patients with known lung disease

[ ] Other (please specify): _____

Test Requested: Please check all that apply:

[ ] Spirometry [ ] Diffusion capacity measurement [ ] Bronchial challenge test

[ ] Fractional exhaled nitric oxide (FeNO) measurement

[ ] Other (please specify): _____

Special Instructions:

[ ] Patient should refrain from smoking for at least 6 hours prior to the test

[ ] Patient should refrain from using bronchodilators for at least 36 hours prior to the test

Physician Information:

Name: _____ Provider #_____

Clinic/Hospital: _____

Phone: _____ Fax: _____

Date of Referral: ___/___/___

Additional Comments/Notes: _____

_____

Signed: _____Date: ___/___/__ Fax to (02) 4942 1938

Patients will be contacted on receipt of referral & an appointment made