Pulmonary Function Lab
St. Joseph's Hospital
268 Grosvenor Street, Room B3-030
London, ON N6A 4V2

Phone: 519-646-6000 ext. 61389
Fax: 519-646-6164

METHACHOLINE CHALLENGE REFERRAL FORM

Please note patient must have had spirometry testing within the last six months in order to schedule

Please complete all sections and FAX to **519-646-6164**

*** Note:** Testing is contra-indicated for 4 weeks post eye surgery.

PATIENT INFORMATION	**REFERRING PHYSICIAN INFORMATION**
Name: _____	Name: _____
Gender: M F	Telephone #: _____
Date of Birth (YYYY/MM/DD) : _____	Fax #: _____
Health Card #: _____	
Telephone #: _____	Signature: _____

CLINICAL INFORMATION:

1. **Reason for Referral** *(Query?):* _____
2. **Respiratory Medications:** ☐ No ☐ Yes (please list)
   Current Respiratory Medications:
   _____
   _____
   _____

****Please review and sign reverse side of form****

PULMONARY FUNCTION LAB USE ONLY

☐ **Appointment Date and Time:** _____

Instructions: _____

Location: St. Joseph's Hospital, 268 Grosvenor St., London, ON, Pulmonary Function Lab, Room B3-030

Please inform patients that they will receive an automated reminder call of their appointment one week prior, to change their preferred contact number they must call 519-646-6019.

☐ **Patient missed or cancelled their appointment. If testing is still required, please re-send referral.**

Please 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.

DRUG	Hours Withheld
ACCOLATE	24
ADVAIR	48
AIROMIR	8
ALVESCO	0
ANORO	3 days
APO-SALVENT	8
ASMANEX	0
ATROVENT	48
BREO	3 days
BRICANYL	8
COMBIVENT	48
DUAKLIR	48
FLOVENT	0
FORADIL	48
FORMOTEROL	48
INCRUSE	48
INSPIOLTO	48
MONTELUKAST	24
ONBREZ	3 days

DRUG	Hours Withheld
OXEZE	248
PULMICORT	0
QVAR	0
SALBUTAMOL	8
SALMETEROL	48
SEEBRI	48
SEREVENT	48
SINGULAIR	24
SPIRIVA	48
SYMBICORT	48
TERBUTALINE	8
TIOTROPIUM	48
TORNALATE	8
TUDORZA	48
ULTIBRO	3 days
VENTOLIN	8
ZAFIRLUKAST	24
ZENHALE	48

I have reviewed the medication list and advised my patient that they may safely withhold the medications as required for testing.

Physician signature: _____ Date:_____