

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

## PULMONARY FUNCTION TEST REFERRAL FORM

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 #: _____	Signature: _____
Telephone #: _____	

### CLINICAL INFORMATION:

1. **Reason for Referral (Query?):** \_\_\_\_\_
  
2. **Respiratory Medications:**                     No                     Yes (please list)  
 Current Respiratory Medications:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
3. **Tests Requested** (please check one only):  
 Full PFTS: Spirometry, Lung Volumes, Diffusing Capacity and O2 Sat.  
 Full PFTS Pre- and Post-Bronchodilator and O2 Sat. **\*please review and sign reverse of this form\***  
 Spirometry and O2 Sat.  
 Spirometry Pre- and Post-Bronchodilator and O2 Sat. **\*please review and sign reverse of this 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.

**If you have referred your patient for a Pre/Post Test 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	0
ADVAIR	24
AIROMIR	4
ALVESCO	0
ANORO	48
APO-SALVENT	4
ASMANEX	0
ATROVENT	6
BREO	48
BRICANYL	4
COMBIVENT	6
DUAKLIR	24
FLOVENT	0
FORADIL	24
FORMOTEROL	24
INCRUSE	24
INSPIOLTO	48
MONTELUKAST	0
ONBREZ	48

DRUG	Hours Withheld
OXEZE	24
PULMICORT	0
QVAR	0
SALBUTAMOL	4
SALMETEROL	24
SEEBRI	24
SEREVENT	24
SINGULAIR	0
SPIRIVA	24
SYMBICORT	24
TERBUTALINE	4
TIOTROPIUM	24
TORNALATE	4
TUDORZA	24
ULTIBRO	48
VENTOLIN	4
ZAFIRLUKAST	0
ZENHALE	24

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

Physician signature: \_\_\_\_\_

Date: \_\_\_\_\_