KINGSTON RESPIRATORY SERVICES

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REQUISITION

Office Use:

Physician/NP Name:
Office Address:
Tel:
Fax:
MOH Billing #:
Copy Report to:

SIGNATURE: _____
Date (DD/MM/YY): _____

PATIENT INFORMATION
Name:
Address:
Tel: (H)
(C)
Date of Birth: ☐ M ☐ F
Health Card: VN:

OR AFFIX STICKER

☐ **RESPIROLOGIST CONSULTATION**
(includes appropriate testing)

REASON FOR REFERRAL: _____

☐ **PULMONARY FUNCTION TESTING**

INDICATION: _____

☐ Full Pulmonary Function Testing, *or specify:*

☐ Spirometry
☐ Pre/Post-bronchodilator Spirometry
☐ Lung Volumes/Diffusion Capacity

Disease Screening:

☐ COPD (spirometry/post-bronchodilator testing)
☐ Asthma (spirometry/post-bronchodilator testing)

Other:

☐ Resting Oxygen Saturation

** Note - Methacholine testing is **no longer available** at our site except by consultation with our Respirologist**

Symptoms of: ☐ cough ☐ wheeze ☐ dyspnea ☐ other _____
Smoking History: ☐ no ☐ previous ☐ current pack-years_____ year quit_____
Reason for Test: ☐ diagnosis ☐ follow-up ☐ other _____

Current Medications: ☐ inh. steroid ☐ short-acting bronchodilator ☐ long-acting bronchodilator
☐ oral steroid ☐ antihistamines ☐ theophylline

PLEASE SEE REVERSE FOR PATIENT INSTRUCTIONS FOR PULMONARY FUNCTION TESTING

Patient Instructions for Pulmonary Function Testing

For ALL breathing tests:

Medication	Minimum Withholding Time (hours)
Short-acting bronchodilators (e.g. salbutamol, terbutaline, ipratropium)	AVOID x 6 HOURS
Long-acting bronchodilators (e.g. salmeterol, formoterol, olodaterol, vilanterol, indacaterol)	AVOID x 24 HOURS
Oral theophylline	AVOID x 48 HOURS

- **NO SMOKING OF ANYTHING** on the day of the test
- **AVOID EATING A HEAVY MEAL** on the day of the test
- **AVOID EXERCISING** prior to the test
- Patients with acute respiratory infection (e.g. cold, flu) will be asked to reschedule