

Pulmonary Function Laboratory Outpatient Requisition

Neuro and Breathing Assessment (A2605)

t: 705-743-2121 x. 2828 | f: 705-876-5840

PATIENT LABEL

Date (DD/MM/YYYY): _____

Precautions: MRSA VRE TB Other: _____

Patient name: _____	WSIB claim #: _____
Patient address: _____	Health card #: _____ VC _____
_____	Referring physician printed name: _____
Patient DOB (DD/MM/YYYY): _____	_____
Age: _____	Referring physician signature: _____
Telephone (H) _____	_____
(W) _____	Other Physician to CC _____

Medications: (inhaled and oxygen):

Clinical information: COPD asthma fibrosis pre-op other: _____

Smoking history: non-smoker past smoker _____ pack/years current smoker _____ pack/years

PULMONARY FUNCTION TESTING

<input type="checkbox"/>	Complete pulmonary function test: Spirometry (flow/volume loops, pre/post 400.0 mcg of salbutamol with spacer given), lung volumes, airway resistance, lung diffusion capacity, and with oximetry at rest
<input type="checkbox"/>	Spirometry (flow/volume loop) <input type="checkbox"/> with post spirometry (400.0 mcg of salbutamol with spacer given)
<input type="checkbox"/>	Neuromuscular evaluation: Upright & Supine Spirometry with upright M.I.P.S./M.E.P.S. (maximal inspiratory and expiratory pressures) with oximetry at rest
<input type="checkbox"/>	Lung volumes (F.R.C., S.V.C., derived volumes)
<input type="checkbox"/>	Lung diffusion capacity and transfer factor
<input type="checkbox"/>	Airway resistance (RAW)
<input type="checkbox"/>	Methacholine challenge test (MCT): (age ≥ 8) with oximetry at rest **Must have a complete pulmonary function test completed at PRHC prior to testing.

MOBILITY STATUS

<input type="checkbox"/> Independent	<input type="checkbox"/> Supervised	<input type="checkbox"/> Standby Assistance	<input type="checkbox"/> Physical Assistance (1 person)
<input type="checkbox"/> Physical Assistance (2+ person)	<input type="checkbox"/> History of falls	<input type="checkbox"/> Non-Ambulatory	

ASSISTIVE DEVICES

<input type="checkbox"/> None	<input type="checkbox"/> Cane	<input type="checkbox"/> Crutches	<input type="checkbox"/> Walker (type: _____)
<input type="checkbox"/> Manual Wheelchair	<input type="checkbox"/> Power Wheelchair	<input type="checkbox"/> Other (specify: _____)	

HOME OXYGEN ASSESSMENT

<input type="checkbox"/>	1. Arterial blood gas (ABG) on room air if SpO2 ≤ 91% <ul style="list-style-type: none"> • If PaO2 ≤ 55mmHg end oxygen assessment • If PaO2 56 - 60 mmHg, perform walking oximetry to demonstrate at least 2 min desaturation (SpO2 ≤ 88%) and then improvement on oxygen 2. If ABG not indicated or PaO2 ≥ 61mmHg perform an independent exercise assessment (IEA)
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ARTERIAL BLOOD GAS (ABG)

<input type="checkbox"/>	ABG <input type="checkbox"/> room air or <input type="checkbox"/> oxygen at _____ lpm (liter per minute) nasal prongs
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OXIMETRY TEST

<input type="checkbox"/>	IEA
<input type="checkbox"/>	6 minute walk <input type="checkbox"/> room air or <input type="checkbox"/> oxygen at _____ lpm nasal prongs
<input type="checkbox"/>	Oximetry at rest <input type="checkbox"/> room air or <input type="checkbox"/> oxygen at _____ lpm nasal prongs

Please fax completed requisition to 705-876-5840