Pulmonary Function Laboratory Outpatient Requisition

Neuro and Breathing Assessment (A2605)

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

PATIENT LABEL

☐ **URGENT REQUEST**

Date (DD/MM/YYYY): _____

Precautions: ☐ MRSA ☐ VRE ☐ TB ☐ Other: _____

Patient name: _____

Patient address: _____

_____

Patient DOB (DD/MM/YYYY): _____

Age: _____

Telephone (H) _____

(W) _____

WSIB claim #: _____

Health card #: _____ VC _____

Referring physician printed name:

_____

Referring physician signature:

_____

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	
☐	**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
☐	**Spirometry (flow/volume loop)** ☐ with post spirometry (400.0 mcg of salbutamol with spacer given)
☐	**Neuromuscular evaluation:** Upright & Supine Spirometry with upright M.I.P.S./M.E.P.S. (maximal inspiratory and expiratory pressures) with oximetry at rest
☐	**Lung volumes** (F.R.C., S.V.C., derived volumes)
☐	**Lung diffusion capacity and transfer factor**
☐	**Airway resistance** (RAW)

MOBILITY STATUS

☐ Independent ☐ Supervised ☐ Standby Assistance ☐ Physical Assistance (1 person)

☐ Physical Assistance (2+ person) ☐ History of falls ☐ Non-Ambulatory

ASSISTIVE DEVICES

☐ None ☐ Cane ☐ Crutches ☐ Walker (type: _____)

☐ Manual Wheelchair ☐ Power Wheelchair ☐ Other (specify: _____)

HOME OXYGEN ASSESSMENT	
☐	**1. Arterial blood gas (ABG) on room air if SpO2 ≤ 91%** · If PaO2 ≤ 55mmHg end oxygen assessment · If PaO2 56 - 60 mmHg, perform walking oximetry to demonstrate at least 2 min desaturation (Sp02 ≤ 88%) and then improvement on oxygen **2. If ABG not indicated or PaO2 ≥ 61mmHg perform an independent exercise assessment (IEA)**

ARTERIAL BLOOD GAS (ABG)	
☐	ABG ☐ room air **or** ☐ oxygen at _____ lpm (liter per minute) nasal prongs

OXIMETRY TEST				
☐	IEA			
☐	6 minute walk	☐ room air	**or**	☐ oxygen at _____ lpm nasal prongs
☐	Oximetry at rest	☐ room air	**or**	☐ oxygen at _____ lpm nasal prongs

Please fax completed requisition to 705-876-5840