ST JOSEPH'S HEALTH CENTRE TORONTO

S0359

PULMONARY FUNCTION CONSULTATION

St. Joseph's Health Centre
East Wing, Room 1E-132
30 The Queensway, Toronto ON

Phone Line: 416-530-6015
Fax Line: 416-530-6702

Name: _____
Male Female
MRN : _____
DOB: _____
Address: _____

Telephone: _____
OHIP #: _____

INCOMPLETE FORMS WILL BE RETURNED AND NOT PROCESSED

☐ Pre-Op Patient ☐ Outpatient ☐ ACC ☐ Urgent Outpatient (within 72 hours)

☐ **FULL PULMONARY FUNCTION TESTS (ADULTS*)** *For patient below minimum ages, please comment in Clinical History
Includes Spirometry/FVL (Bronchodilator administered if obstructed), Lung Volumes, Diffusion Capacity, SpO_2 at rest
☐ Diffusion Capacity only ☐ Lung Volumes/Plethysmography only ☐ Bronchodilator not to be given

OTHER PULMONARY FUNCTION TESTS (AGES 7+*) *This section will be ignored if Full PFT (above) is selected.*
☐ Spirometry only - via FVL (Flow Volume Loop) test ☐ Pre & Post Bronchodilator Spirometry only ☐ SpO_2

EXERCISE TESTING (Wear comfortable footwear)

☐ SpO_2 On Exertion
☐ Six Minute Walk Test
☐ Cardio-Pulmonary Stress Test
☐ Exercise Oxygen Assessment for Home Oxygen
☐ ABG and Exercise Oxygen Assessment for Home Oxygen
☐ Exercise Induced Asthma Test (if Methacholine Challenge negative)

OTHER
☐ **Methacholine Challenge**
☐ Arterial Blood Gas (ABG)
☐ Maximal Inspiratory/ Expiratory Pressure (MIP/MEP)

Methacholine Challenge testing is NOT booked on the same day as Routine Pulmonary Function testing*
****Methacholine preparation:**-No short-acting bronchodilators 8 hours prior to test. No long-acting bronchodilators, steroids or antihistamines 48 hours prior to test. No anticholinergics/montelukast 24 hours prior to test. Test not done during pregnancy or while breastfeeding.*

CLINICAL HISTORY/REASON FOR TEST

ADDITIONAL INFORMATION

☐ Falls Risk ☐ Lifting Device Required ☐ Patient with Restraints (must be accompanied)

Does Patient Consent to Appointment Information Being Disclosed in a Telephone Message? ☐ Yes ☐ No

Is Patient Able to Come in on Short Notice? ☐ Yes ☐ No

Contact Telephone Number (& Name): _____

Patient E-mail: _____ Send MyChart invitation once this form is recieved?
☐ Yes (e-mail) ☐ Yes (SMS) ☐ No

REQUESTING PHYSICIAN

Address: _____ City: _____ Postal Code:

Telephone Number: _____ Fax: _____ CPSO #:

Copy to: _____ MD/NP (Copied Provider(s)' Name(s))

DATE/TIME	SIGNATURE	PRINT NAME
DD / Month / YYYY ____:____h		

Reset Form

(archive: 04/2006, 06/2016)