ST. JOSEPH'S
UNITY HEALTH 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

☐ Urgent Outpatient (within 72 hours) ☐ Preoperative Patient

☐ **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) - *Please select only one type of exercise test*
☐ SpO_2 On Exertion
☐ Six Minute Walk Test
☐ Exercise Oxygen Assessment for Home Oxygen
☐ ABG and Exercise Oxygen Assessment for Home Oxygen

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

Methacholine Challenge testing is NOT booked on the same day as Routine Pulmonary testing, recent PFT report required*
***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 ***Contact info. is optional, but please provide parent/guardian details for paediatric patients***
☐ 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
Able to Come in on Short Notice? ☐ Yes ☐ No Requires interpreter for: _____ *Please Specify Language* _____
Contact: *Please Specify name, relation to patient, phone number and for MyChart: date of birth or OHIP#* _____
E-mail: *Can be patient's or contact's* _____ ☐ Contact's E-mail?
Send MyChart invitation once this form is received? ☐ 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)