



Pulmonary Function Laboratory

Room 1C42 - 4480 Oak Street

Vancouver, BC V6H 3V4

Phone: 604-875-2119

Fax: 604-875-3293

Therapist Line: 604-875-2956

BC Children's Hospital office use only

Request for Pulmonary Function Tests

Spirometry can only be performed on patients aged *six (6)* years and older.

Incomplete and illegible requisitions will not be processed.

Referring Doctor: _____

Billing #: _____

Doctor's Signature: _____

Phone: _____

(we do **NOT** accept medical students'/residents'/fellows' signature on behalf of referring doctor)

Fax: _____

Patient Name: _____ PHN: _____

Date of Birth (dd/mm/yyyy): _____ Telephone #: _____

Address: _____

Reason for Referral: _____

Additional pertinent/relevant medical history: _____

Current Medications: _____ Allergies: _____

Infectious diseases (if known) _____

Translator required? (for the patient) Yes / No If yes, language _____

Previous PF test? Yes / No if yes, location _____

PLEASE CHECK OFF REQUIRED TEST:

Spirometry (FVC,FEV1,flow volume loop)

- | | | | |
|--------------------------|---|--------------------------|-----------------------------|
| <input type="checkbox"/> | Pre Bronchodilator | <input type="checkbox"/> | Pre and Post Bronchodilator |
| <input type="checkbox"/> | Lung diffusion (last Hgb value collected must be provided) Hgb:_____ Date:_____ | | |
| <input type="checkbox"/> | He Dilution lung volumes | | |
| <input type="checkbox"/> | Plethysmography (body box) for airway resistance and lung volumes | | |
| <input type="checkbox"/> | Exercise Test (available only with REFERRAL to a respirologist first) | | |
| <input type="checkbox"/> | Methacholine Challenge (available only with a REFERRAL to a respirologist first) | | |
| <input type="checkbox"/> | Oximetry | | |

**** Please note that we will contact your office via fax with appointment date and time ****