SACRAMENTO IMAGING

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P: (916) 905.5363
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PULMONARY FUNCTION TESTING REFERRAL FORM

Please fax this form to 916 877-7693

not completing this form as 'fillable' pdf on a computer, then please print clearly using dark black ink (for fax)

* Important patient instructions on page 2.

1 REFERRAL REQUEST

A ☐ **COMPLETE PFT**
Includes:
- spirometry,
- diffusing capacity, and
- measurement of lung volumes

OR

B ☐ **SPIROMETRY**
pre/post bronchodilator admin

☐ **SPIROMETRY**
without bronchodilator

C **ADDITIONAL:**
☐ **DIFFUSION CAPACITY**
☐ **LUNG VOLUMES**
☐ **MIPS/MEPS**

2 PATIENT INFORMATION

Surname	
First name	
OHIP Number	
Birth Date (Month/Day/Year)	
Gender	☐ M ☐ F
Home Phone	
Work Phone	
Fax number	
Email	
Name of Family Physician	

CLINICAL INFORMATION

Diagnosis

Booking Timeframe ☐ Next available ☐ Not before:

INDICATION FOR TEST

☐ Objective Assessment / Diagnosis
☐ Guide to Treatment
☐ Routine Follow-up
☐ Pre/Post-op Assessment
☐ Chemotherapy/Amiodarone
☐ Other: please explain

REQUESTING PHYSICIAN

Physician name	
Billing Number	
Street Address	
Town/City	Postal Code
Clinic Phone	
Clinic Fax	
Clinic Email	

3 MEDICAL HISTORY

Smoking	☐ Yes	☐ No	
Bronchodilator	☐ Yes	☐ No	
Steroid Therapy	☐ Yes	☐ No	
Home Oxygen	☐ Yes	☐ No	______ L / minute
Antihistamine	☐ Yes	☐ No	
Beta-blocker	☐ Yes	☐ No	
Recent hospitalization / illness	☐ Yes	☐ No	

EXISTING CONDITIONS

☐ **ALLERGIES**
Please list:

☐ **SPECIAL NEEDS**
☐ Communications
☐ Hearing
☐ Mobility
☐ Other – please explain:

7 PHYSICIAN'S AUTHORIZATION

Signature:

Date of request :______________________________

☐ Please check if you would like us to send you more referral forms.

FOR OFFICE USE USE ONLY

APPT DATE	TIME	DATE OF F/U
REBOOK DATE	TIME	NOTES

Important Patient Instructions!

Please arrive 10 minutes before your appointment.

**Remember if you are more than 10 minutes late,
your appointment may be rescheduled.**

- ☐ The test is 30 minutes in duration.
  Wear loose, comfortable clothing.
- ☐ If you have a cold, fever, or feel unwell, please let us know as your appointment may need to be rebooked.
- ☐ If you have puffers and a spacer device (Aerochamber), please bring them with you to the test.

8 hours prior to test

Do not take Serevent, Svair, Symbicort, Oxeze, Spiriva.

4 hours prior to test

Do not smoke for the 24 hours before your test. Do not take Atrovent, Combivent, Singulair.

8 hours prior to test

Do not take Ventolin/Salbutamol, Atrovent, Bricanyl, Airomir, Apo-Salvent, Berotec.

Thank you!