NIAGARA PULMONARY
medicine & diagnostics

Niagara Pulmonary Medicine & Diagnostics
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Patient Information

Full Name: ____
Last *First* *M.I.*

Address: ____
Street Address *Apartment/Unit #*

____
City *Province* *Postal Code*

Home Phone: ____________________ Alternate Phone: ____________________

OHIP: ____

Request Information

Reason for Referral :

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Please check one:

☐ 1. **Consultation and FULL Pulmonary Function Testing** (pre and post bronchodilator, lung volumes, DLCO and oxygen saturation by pulse oximetry).

☐ 2. **Consultation only**

☐ 3. **Full Pulmonary Function Testing only** (spirometry, lung volumes, diffusion, pre and post bronchodilator)

☐ without post bronchodilator testing

☐ 4. **Spirometry only**

☐ without post bronchodilator testing

Referring Physician Information

Referring MD: ____________________ Address: ____________________

Signature: ____________________ ____________________

Billing Number: ____________________ ____________________

Date (dd/mm/yyyy): ____________________ Phone: ____________________

Cc: ____________________ Fax: ____________________