NIAGARA PULMONARY
medicine & diagnostics

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**WE AIM TO HAVE NEW REFERRALS SEEN BY THE 1ST AVAILABLE RESPIROLOGIST.**

## Patient Information

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

Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *Province* *Postal Code*

Phone: _____ DOB (YYYY/MM/DD): _____

OHIP: _____

## Request Information

**Reason for Referral:**

_____

_____

**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

(Please note, cardiopulmonary exercise testing can be requested by respirologists, cardiologists or thoracic surgeons only. The request will be done in addition to a consultation.)

## Referring Physician Information

Referring MD: _____ Address: _____

Signature: _____ _____

Billing Number: _____ Phone: _____

Date (dd/mm/yyyy): _____ Fax: _____