

Office Use Only

Appointment Date and Time: _____

Patient Health Record #: _____

Cardiorespiratory Services Requisition

Patient Name: _____	Alternate Phone #: _____
Date of Birth (dd/mm/yyyy): _____	Health Card #: _____
Telephone #: _____	WSIB#: _____
Patient will be notified by email, if email provided. (Patient understands email may not allow secure communication)	Patient Email: _____

Clinical Information _____

Medication List (required): _____

Pulmonary Function Testing

- q **Full PFT** (refer to protocol): (Hemoglobin required for Diffusion)
 Pre/Post SABA (400mcg Ventolin) Spirometry, Volumes, Diffusion Hb ____, Airway Resistance, O₂ Saturation
 (No smoking, caffeine, or puffers 4-6 hours prior to test, bring puffers to test if available)
- q **Spirometry Pre/Post SABA (400 mcg Ventolin):** (for screening and/or follow-up)
 (No smoking, caffeine, or puffers 4-6 hours prior to test, bring puffers to test if available)
- q **Spirometry Only** (No smoking, caffeine, or puffers 4-6 hours prior to test, bring puffers if available)
- q **Arterial Blood Gases:**
 - q Room Air
 - q For Home O₂
 - q On O₂ ____ L/m
- q **Oximetry**
 - q At rest
 - q With exercise (6 minutes brisk walking – may include stairs)
 - q Overnight

Cardiology Test

- q **Stress Testing (Stress Test Only - Internal Medicine consultation is not included if ordered on this form)**
 Please include relevant clinical information above. Includes Exercise Oximetry. Running shoes and medication list required. Ladies should wear a bra and a loose fitting, short sleeved blouse or t-shirt.
- q **Ambulatory Blood Pressure Monitoring:**
 Instructions: Please wear a loose short sleeved top. Test is not covered by OHIP. You will be invoiced. Bring a medication list.
- q **Electrocardiogram (ECG/EKG)**
 Instructions: Please don't use oils/powders on chest/arms/legs prior to testing.
- q **Holter Monitor:** q24hour q48hour q14 days
 Instructions: Please don't use oils/powders on chest/arms/legs prior to testing. Ladies should wear a bra and a loose fitting blouse or t-shirt. Please bring medication list.

REFERRING PHYSICIAN:

Practitioner's Name (Print) _____ Address: _____

City: _____ Postal Code: _____ Tel: _____ Fax: _____

Physician's Signature: _____ Billing No: _____

Copy to: _____ Date: _____
 (dd/mm/yyyy)