NORTHERN
PULMONARY DIAGNOSTICS

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Pulmonary Health Referral

PRIORITY: ☐ Urgent ☐ Routine

PATIENT INFORMATION

Name: _____ Gender: ☐ M ☐ F

Address: _____

Phone: _____ Alternate Phone: _____

Date of Birth: _____ ULI / Health Card #: _____

REQUISITION FOR

☐ Pulmonary Consult (Includes all necessary Pulmonary Tests as directed by Respirologist. Please include any relevant medical info in comments)

☐ Full Pulmonary Function Test

☐ Spirometry (Pre/Post)

☐ Arterial Blood Gas (If $PaO_2 \leq 59$ mmHg, initiate home O_2)

☐ Methacholine Challenge Test

☐ Sleep Apnea Testing / Treatment (Level III Sleep Study [HSAT] Assessment, AutoCPAP Trial and Treatment, please add reason for referral in comments) *

REASON FOR REFERRAL

☐ Asthma ☐ COPD ☐ Dyspnea ☐ Cough ☐ ILD ☐ Screening ☐ Occupational Exposure

☐ Abnormal Imaging ☐ Pre-Op Assessment ☐ Other: _____

COMMENTS

REFERRING PHYSICIAN

Physician Name: _____ PRACID: _____

Phone: _____ Fax: _____

Signature: _____ Referral Date: _____

CC: _____

Fax completed form to (780) 447-6575

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