YRPFT
YORK REGION PULMONARY FUNCTION TESTING CENTRE

PULMONARY FUNCTION LABORATORY

ROUTINE TEST REQUEST

13291 Yonge Street Suite 401
Richmond Hill, ON L4E 4L6
PHONE 905.751.2932 FAX 905.773.5180

Addressograph

Please check ☑ appropriate boxes below.)

☐ PFT ONLY ☐ PFT with consultation if abnormal results

☐ Referral for COPD rehabilitation program
☐ Consultation with lung specialist and PFT if indicated

Appointment Date _____ Appointment Time _____ Patient's Phone No. ( ) _____

Referring Physician _____ Phone No. ( ) _____

Address _____ Fax No. ( ) _____

Send Reports To: _____

ROUTINE STUDIES

☐ Complete Study (includes all routine studies)
☐ Spirometry
☐ Spirometry after Bronchodilator
☐ Lung Volume Measurement and Airway Resistance Tests
☐ Diffusion Capacity

OTHER TESTS

☐ Non-Specific Bronchial Provocative Test (Methacholine)
☐ Arterial Blood Gas on Room Air
☐ Maximal Inspiration and Expiration Pressures
☐ Arterial Blood Gas on Oxygen _____ L/Min
☐ 6-Minute Walking Oximetry
☐ Oxygen Saturation at Rest

HOME OXYGEN ASSESSMENT

☐ Initial Assessment with Arterial Blood Gas on Room Air
☐ Initial Assessment: Without Arterial Blood Gas
(previous ABG done within last 30 Days)
☐ Home Oxygen Setup (Oxygen Prescription Required for Setup)
☐ Independent Exercise Assessment (IEA)

PRESENT SMOKER

☐ Yes ☐ No ☐ _____ Cigarettes/Day For _____ Years

EX-SMOKER

Stopped _____ Years Ago
Did Smoke _____ Cigarettes/Day For _____ Years

CLINICAL INFORMATION

Hgb Level: _____

Does Treatment Include:

Bronchodilator	☐ YES	☐ NO
Steroids	☐ YES	☐ NO

Precautions:

Possible TB	☐ YES	☐ NO
Other Infectious Disease	☐ YES	☐ NO

If Yes, Please give Details:

_____
_____
_____
_____

REASON FOR TEST (MANDATORY INFORMATION)

☐ Diagnosis
☐ Medical Follow-up
☐ Pre-surgical Assessment*
☐ Surgical Follow-up
☐ Medical-Legal
☐ Other: _____

*Please state which surgery _____

PREVIOUS PULMONARY FUNCTION TEST? ☐ YES ☐ NO

Physician Signature _____ Date _____