Pulmonary Function Laboratory Requisition Strathroy Middlesex General Hospital 395 Carrie Street Strathroy, Ontario (T) 519-245-5295 ext. 5440 (F) 519-246-5919	Patient Information Name:_____ Address:_____ _____ Phone Number: _____ DOB:_____ Health Card: _____VC___

Ordering /Attending Physician:

_____

Diagnosis:

_____

_____

Reporting Physician:

_____

(office use only)

Current Respiratory Medications:
(list meds, dosage, & frequency)

_____

_____

_____

☐ Copy to Family Physician:
_____

☐ Copy to:
_____
(Outpatients)

☐ Fax Results to:_____

Clinical Information:

_____

_____

_____

PLEASE SELECT TESTS

Select One Only

- ☐ Spirometry Only
- ☐ Spirometry Pre and Post
- ☐ Full Screen PFT
- ☐ Full screen pre and post

Additional Testing

- ☐ Arterial Blood Gases
- ☐ MDI Teaching
- ☐ COPD education

*Please see reverse for explanation/details of various test and patient instructions.
**ABG`s cannot be performed on patients receiving anticoagulant therapy without recent INR results. Please indicate under clinical information.

Referring Physician(Print)_____Signature_____

Physician Phone #_____ Date_____