AIRDRIE PFT LAB
#120 - 52 Gateway Drive NE
Airdrie, AB
T4B 0J6
587 254-3071 Phone
403 316-0131 Fax

PHYSICIAN PATIENT REFERRAL FORM

1 REFERRAL REQUEST

A ◯ COMPLETE PFT	B ◯ SPIROMETRY	C ADDITIONAL
Includes: - Spirometry, - Diffusing capacity, and - Measurement of lung volumes	pre/post bronchodilator admin ◯ **SPIROMETRY** without bronchodilator	☐ **MIPS/MEPS** **Other** _____

2 PATIENT INFORMATION

Surname:
First name:
PHN Number:
Birth Date (Month/Day/Year)
Gender: ◯ M ◯ F
Home Phone:
Work Phone:
Fax Number:
Email:
Name of Family Physician:

3 MEDICAL HISTORY

Smoking:	◯ yes	◯ no	
Bronchodilator:	◯ yes	◯ no	
Steroid therapy:	◯ yes	◯ no	
Home oxygen:	◯ yes	◯ no	L/minute
Antihistamine:	◯ yes	◯ no	
Beta-blocker:	◯ yes	◯ no	
Recent hospitalization / illness:	◯ yes	◯ no	

4 EXISTING CONDITIONS

☐ ALLERGIES
Please list:

SPECIAL NEEDS
- ☐ Communications
- ☐ Hearing
- ☐ Mobility
- ☐ Other (explain)

5 CLINICAL INFORMATION

Diagnosis:

INDICATION FOR TEST

- ☐ Objective Assessment
- ☐ Diagnosis
- ☐ Guide to Treatment
- ☐ Routine Follow-up
- ☐ Pre/Post-op Assessment
- ☐ Chemotherapy/Amiodarone
- ☐ Other (explain)

6 REQUESTING PHYSICIAN

Physician name:	
Prac ID #	
Street Address:	
Town/City:	Postal Code:
Clinic Phone:	
Clinic Fax:	
Clinic Email:	

7 PHYSICIAN'S AUTHORIZATION

Signature:

Date of Request:

PLEASE COMPLETE, PRINT, AND FAX THIS FORM TO: AIRDRIE PFT LAB 403-316-0131