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



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 Includes: - Spirometry, - Diffusing capacity, and - Measurement of lung volumes B SPIROMETRY pre/post bronchodilator admin SPIROMETRY without bronchodilator C ADDITIONAL MIPS/MEPS Other

Surname: First name: PHN Number: Birth Date (Month/Day/Year) Gender: M F Home Phone: Work Phone: Fax Number: Email: Name of Family Physician: Smoking: yes no Bronchodilator: yes no Steroid therapy: yes no Home oxygen: yes no Beta-blocker: yes no Recent hospitalization yes no Recent hospitalization yes no ALLERGIES Please list: ALLERGIES Please list: ALLERGIES Please list: Diagnosis: INDICATION FOR TEST Objective Assessment Pre/Post-op Assessment Diagnosis Chemotherapy/Amiodarone Guide to Treatment Routine Follow-up Other (explain) For ID # Street Address: Town/City: Postal Code: Clinic Phone: Clinic Fax: Clinic Fax: Clinic Email: 7 PHYSICIAN'S AUTHORIZATION Signature:	2 PATIENT INFORMATION				5 CLINICAL INFORMATION		
First name: PHN Number: Birth Date (Month/Day/Year) Gender: M F Home Phone: Work Phone: Fax Number: Email: Name of Family Physician: Smoking: yes no Bronchodilator: yes no Steroid therapy: yes no Home oxygen: yes no Beta-blocker: yes no Beta-blocker: yes no Recent hospitalization yes no ALLERGIES Please list: Birth Date (Month/Day/Year) Birth Date (Month/Day/Year) A F INDICATION FOR TEST Objective Assessment Pre/Post-op Assessment Diagnosis Chemotherapy/Amiodarone Guide to Treatment Routine Follow-up Other (explain) For ID # Street Address: Town/City: Postal Code: Clinic Phone: Clinic Fax: Clinic Fax: Clinic Email: 7 PHYSICIAN'S AUTHORIZATION Signature:							
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