

IMPROVING HEALTH THROUGH BETTER SLEEP • ACROSS CANADA

MedSleep clinics provide clinical consultation, diagnostic services (sleep testing) and treatment for the full spectrum of sleep disorders

## **PULMONARY FUNCTION TESTING REFERRAL FORM**

**Please fax this form to 905-456-8768**

**If not completing this form as 'fillable' pdf on a computer, then please print clearly using dark black ink (for fax)**

\* Important patient instructions on page 2.

### **1 REFERRAL REQUEST**

- A**  **COMPLETE PFT** **OR** **B**  **SPIROMETRY** pre/post bronchodilator admin
- Includes:
- spirometry,
  - diffusing capacity, and
  - measurement of lung volumes
- SPIROMETRY** without bronchodilator
- C** **ADDITIONAL:**
- DIFFUSION CAPACITY**
  - LUNG VOLUMES**
  - MIPS/MEPS**

### **2 PATIENT INFORMATION**

Surname
First name
OHIP Number
Birth Date (Month/Day/Year)
Gender <input type="checkbox"/> M <input type="checkbox"/> F
Home Phone
Work Phone
Fax number
Email
Name of Family Physician

### **3 MEDICAL HISTORY**

Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchodilator	<input type="checkbox"/> Yes <input type="checkbox"/> No
Steroid Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home Oxygen	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ L / minute
Antihistamine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Beta-blocker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recent hospitalization / illness	<input type="checkbox"/> Yes <input type="checkbox"/> No

### **4 EXISTING CONDITIONS**

<input type="checkbox"/> <b>ALLERGIES</b> Please list:	<input type="checkbox"/> <b>SPECIAL NEEDS</b>
	<input type="checkbox"/> Communications
	<input type="checkbox"/> Hearing
	<input type="checkbox"/> Mobility
	<input type="checkbox"/> Other – please explain:

### **5 CLINICAL INFORMATION**

Diagnosis
Booking Timeframe <input type="checkbox"/> Next available <input type="checkbox"/> Not before:
<b>INDICATION FOR TEST</b>
<input type="checkbox"/> Objective Assessment / Diagnosis <input type="checkbox"/> Pre/Post-op Assessment
<input type="checkbox"/> Guide to Treatment <input type="checkbox"/> Chemotherapy/Amiodarone
<input type="checkbox"/> Routine Follow-up <input type="checkbox"/> Other: please explain

### **6 REQUESTING PHYSICIAN**

Physician name
Billing Number
Street Address
Town/City <span style="float: right;">Postal Code</span>
Clinic Phone
Clinic Fax
Clinic Email

### **7 PHYSICIAN'S AUTHORIZATION**

Signature:
Date of request : _____
<input type="checkbox"/> Please check if you would like us to send you more referral forms.

#### **FOR OFFICE USE USE ONLY**

APPT DATE	TIME	DATE OF F/U
REBOOK DATE	TIME	NOTES

# MedSleep

## Important Patient Instructions!

**Please arrive 10 minutes before your appointment.**

**Remember if you are more than 10 minutes late,  
your appointment may be rescheduled.**

- The test is 30 minutes in duration.  
Wear loose, comfortable clothing.
- If you have a cold, fever, or feel unwell, please let us know  
as your appointment may need to be rebooked.
- If you have puffers and a spacer device (Aerochamber),  
please bring them with you to the test.

### 48 hours prior to test

Do not take Serevent, Svair, Symbicort, Oxeze, Spiriva.

### 24 hours prior to test

Do not smoke for the 24 hours before your test.

Do not take Atrovent, Combivent, Singulair.

### 8 hours prior to test

Do not take Ventolin/Salbutamol, Atrovent, Bricanyl,  
Airomir, Apo-Salvent, Berotec.

*Thank you!*