MedSleep

Brampton Pulmonary Function Testing
216-40 Finchgate Blvd • Brampton ON L6T 3J1
Office Phone: 905-456-3699 • Office Fax: 905-456-8768
brampton@medsleep.com • www.medsleep.com

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

* **IMPORTANT** patient instructions on page 2

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

1 REFERRAL REQUEST

A ☐ **COMPLETE PFT**
- pre/post bronchodilator admin
- diffusing capacity, and
- measurement of lung volumes

☐ **OR** as above, without bronchodilator

OR

B ☐ **SPIROMETRY** pre/post bronchodilator admin

☐ **SPIROMETRY** without bronchodilator

C **ADDITIONAL:**
☐ **DIFFUSION CAPACITY**
☐ **LUNG VOLUMES**
☐ **MIPS/MEPS**

D **ADDITIONAL DIAGNOSTIC/ CLINICAL INFORMATION / MEDICATION**

2 PATIENT INFORMATION

Surname	
First name	
OHIP Number	
Birth Date (Month/Day/Year)	
Gender	☐ M ☐ F
Home Phone	
Work Phone	
Cell number	
Email	
Name of Family Physician	

3 CLINICAL INFORMATION

Smoking ☐ Yes ☐ No _____packs/yr_____
Bronchodilator ☐ Yes ☐ No _____medication_____
Steroid Therapy ☐ Yes ☐ No _____
Home Oxygen ☐ Yes ☐ No _____
Hgb gm/L* ☐ Yes ☐ No _____
*** IF YES,** indicate dates, if known _____
Beta-blocker ☐ Yes ☐ No _____
Cardiac Disease ☐ Yes ☐ No _____

4 EXISTING CONDITIONS

☐ **ALLERGIES**
Please list:

☐ **SPECIAL NEEDS**
- ☐ Communications
- ☐ Hearing
- ☐ Mobility
- ☐ Other – please explain:

5 CLINICAL DIAGNOSIS

Diagnosis

Booking Timeframe ☐ Next available ☐ Not before:

INDICATION FOR TEST

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

6 REQUESTING PHYSICIAN

Physician name	
Billing Number	
Street Address	
Town/City	Postal Code
Clinic Phone	
Clinic Fax	
Clinic Email	

7 PHYSICIAN'S AUTHORIZATION

Signature:

Date of request :_____

☐ 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.

48-36 hours prior to test

DO NOT TAKE
Spiriva, Incruse, Anoro, Trelegy
Seebri, Ultibro, Tudoza

36 hours prior to test

DO NOT TAKE
take Breo, Ultibro, Inspiolto

24 hours prior to test

DO NOT SMOKE for the 24 hours before your test

DO NOT TAKE
Advair, Serevent, Symbicort, Zenhale

12 hours prior to test

DO NOT TAKE
Atrovent, Combivent *Ipratropium*

4-6 hours prior to test

DO NOT TAKE
Ventolin *Salbutamol,* Airomir

Thank you!