MedSleep

Carleton Place Sleep and Respiratory Clinic
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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 613-257-0021

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**

Includes:
- spirometry,
- diffusing capacity, and
- measurement of lung volumes

OR

B ☐ **SPIRONETRY**

☐ **SPIROMETRY**
pre/post bronchodilator admin

☐ **SPIROMETRY**
without bronchodilator

C **ADDITIONAL:**
- ☐ **IEA - Independent Exercise Assessment**
- ☐ **DIFFUSION CAPACITY**
- ☐ **LUNG VOLUMES**
- ☐ **MIPS/MEPS**

2 PATIENT INFORMATION

Surname

First name

OHIP Number VC

Birth Date (Month/Day/Year)

Gender ☐ M ☐ F

Home Phone

Work Phone

Fax number

Email

Name of Family Physician N/P

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 – please explain:

5 CLINICAL INFORMATION

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 N/P

Name

Billing Number

Street Address

Town/City | Postal Code

Clinic Phone

Clinic Fax

Clinic Email

7 PHYSICIAN/NP 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

Med*Sleep*

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!