Bluewater
SLEEP DISORDER CLINIC
www.bluewatersleep.ca
staff@bluewatersleep.ca

1258 Michigan Ave SARNIA ON N7S 3Y2
519-332-5333
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PULMONARY FUNCTION TEST (PFT)

PATIENT INFORMATION:

Name _____ **Height** _____ **Weight** _____ **M / F**

HCN _____ **Version** _____ **Birthdate** _____ **Age** _____

Home Phone _____ **Cell Phone** _____ **Email** _____

Street _____ **City** _____ **Postal Code** _____

HEALTH CARE PROVIDER INFORMATION:

Name _____ **OHIP billing #** _____ **Phone** _____

Fax _____ **Email** _____ **Signature** _____

Family Health Care Provider _____ **Date** _____

Symptoms Leading to Referral:

☐ Asthma
☐ COPD
☐ Cough
☐ Wheezing
☐ Pulmonary Fibrosis
☐ SOB/Dyspnea
  ☐ Pre-Op
  ☐ Follow up
☐ Other _____

_____

Hgb:_____g/L on _____
yyyy/mm/dd

Special Needs:

☐ Hearing Impaired
☐ Translator
☐ Vision Impairment
☐ Caregiver Required
☐ Other: _____

_____

_____

Is the patient a smoker?

☐ Yes ☐ No

If Yes, number of packs/year

_____

☐ Life-time non-smoker

Provisional Diagnosis:

_____

_____

_____ **Suspected TB is a contraindication for testing.**

TB Suspected ☐ Yes. **If yes, test cancelled**

List of Medications:
Please Indicate if the Patient is currently using:

☐ Bronchodilator
☐ Inhaled Steroid (ICS)
☐ Oral Steroid
☐ Leukotriene Receptor Antagonists
☐ Other: _____

ASSESSMENT REQUESTED:

☐ **Full PFT including Flow Volume Loop (pre/post), lung volumes, diffusing capacity**
☐ **Pre and Post Spirometry**
☐ **Spirometry**
☐ **Diffusing Capacity Only**
☐ **Lung Volumes Only**
☐ **Maximum Inspiratory and Expiratory Pressures (MIP/MEP)**
☐ **Oxygen Saturation by Oximetry at Rest**

This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHFs, such as those listed on the IHF Program website: http://www.health.gov.on.ca/en/public/programs/ihf/facilites.aspx.