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Sunshine Coast Respiratory & Sleep

Dr. Timothy Baird
Dr. James Anderson
Dr. Andrew Pattison

LUNG FUNCTION REQUEST FORM

Patient Details:

Surname: .... First Name: ....

Address: ....

DOB: .... Home Ph: ....

Work: .... Mobile: ....

Clinical History/Details: ....

....

....

Tests:

- ☐ Full Lung Function (Spirometry & Flow Volume Loops – before and after Bronchodilator; Lung Volumes; Gas Transfer)
- ☐ Spirometry & Gas Transfer
- ☐ Spirometry & Flow Volume Loops (before and after Bronchodilator)
- ☐ Spirometry & FeNO
- ☐ Postural Spirometry (Seated and Supine)
- ☐ Respiratory Muscle Strength (MIPS/MEPS and Postural Spirometry)
- ☐ Bronchial Provocation (Mannitol Challenge)
- ☐ Six Minute Walk Test (without O2)
- ☐ Six Minute Walk Test (without and with supplemental O2)

Referring Doctor Details:

Doctors Name: .... Signature: ....

Address: ....

Provider No: .... Date of Referral: ....

Email/Fax Report: .... Copy of Report to: ....

Please send your referral via MO, email or fax and mark your preference for how you wish to receive your report:

☐ MO ☐ Email ☐ Fax