St. Mary's General Hospital
435 The Boardwalk, Suite 306
Waterloo ON N2T 0C2
Tel: 226-896-2026

Airway Clinic
Diagnostics Referral Form

Patient Label

PLEASE FAX REFERRAL FORM TO 226-896-2030

Please call the Airway Clinic at 226-896-2026 if you have any questions or concerns

Patient Name: _____ HCN#: _____

Date of Birth: _____ Gender: □ Male □ Female

Parent Name (if applicable): _____

Address: _____

_____

Phone (Home): _____ (Work): _____

Referring Physician/Nurse Practitioner: _____ CPSO #: _____

Family Physician (if different from referring provider) _____

Medication Instructions: Patient to □ hold inhalers day of test □ take inhales as prescribed

Reason for Referral:

□ Enable Diagnosis of a pulmonary disorder

Symptoms: _____

□ Follow up assessment. Current Diagnosis: _____

□ Other: _____

Procedure

□ **Pulmonary Function Testing** (must be ≥ 12 years of age) includes spirometry, lung volumes, diffusion capacity, oxygen saturation, post bronchodilator testing if meets criteria

□ *post bronchodilator testing to be completed regardless of results*

□ **Spirometry Testing** includes oxygen saturation, post bronchodilator testing if meets criteria

□ *post bronchodilator testing to be completed regardless of results*

□ **Arterial Blood Gases**

Please indicate: □ Room Air □ On Oxygen _____ liters per minute

□ **Cardio-Pulmonary Exercise Testing (C-PET)** to be ordered by Respirologists **only**

□ **Individual Exercise Assessment for Home Oxygen** to be ordered by Respirologists **only**

□ **6 Minute Walk Test** to be ordered by Respirologists **only**

□ **Fraction of Exhaled Nitric Oxide Test** for asthma diagnosis and management

Signature of Referring Provider: _____ Date: _____

Provider Address: _____

Provider Phone number: _____ Fax: _____

SMGH Airway Clinic Response: Please notify your patient an appointment has been scheduled for:

Date: _____ **Time:** _____