

Office Use Only

Appointment Date and Time: _____

Patient Health Record #: _____

Cardiorespiratory Services Requisition

Patient Name: _____ Alternate Phone #: _____
 Date of Birth (dd/mm/yyyy): _____ Health Card #: _____
 Telephone #: _____ WSIB#: _____

Clinical Information _____

Medication List (required): _____

Pulmonary Function Testing

- Full PFT** (refer to protocol): (Hemoglobin required for Diffusion)
 Pre/Post SABA (400mcg Ventolin) Spirometry, Volumes, Diffusion Hb ____, Airway Resistance, O₂ Saturation
 (No smoking, caffeine, or puffers 4-6 hours prior to test, bring puffers to test if available)
- Spirometry Pre/Post SABA (400 mcg Ventolin):** (for screening and/or follow-up)
 (No smoking, caffeine, or puffers 4-6 hours prior to test, bring puffers to test if available)
- Spirometry Only** (No smoking, caffeine, or puffers 4-6 hours prior to test, bring puffers if available)
- Arterial Blood Gases:**
 - Room Air For Home O₂ On O₂ ____ L/m
- Oximetry**
 - At rest
 - With exercise (6 minutes brisk walking – may include stairs)
 - Overnight

Cardiology Test

- Stress Testing (Stress Test Only - Internal Medicine consultation is not included if ordered on this form)**
 Please include relevant clinical information above. Includes Exercise Oximetry. Running shoes and medication list required. Ladies should wear a bra and a loose fitting, short sleeved blouse or t-shirt.
- Ambulatory Blood Pressure Monitoring:**
 Instructions: Please wear a loose short sleeved top. Test is not covered by OHIP. You will be invoiced. Bring a medication list.
- Electrocardiogram (ECG/EKG)**
 Instructions: Please don't use oils/powders on chest/arms/legs prior to testing.
- Holter Monitor:** 24hour 48hour 14 days
 Instructions: Please don't use oils/powders on chest/arms/legs prior to testing. Ladies should wear a bra and a loose fitting blouse or t-shirt. Please bring medication list.

REFERRING PRACTITIONER:

Practitioner's Name (Print) _____ Address: _____
 City: _____ Postal Code: _____ Tel: _____ Fax: _____
 Practitioner's Signature: _____ Billing No: _____ CPSO/CNO/Reg. No: _____
 Copy to: _____ Date: _____
(dd/mm/yyyy)