

**Chinook Lung Function Clinic
204 542 7 Street South
Lethbridge AB T1J 2H1
403-327-7675**

I, _____ give consent to the staff and doctors at the Chinook Lung Function Clinic to perform a Cardio-Pulmonary Exercise test and any medical care or procedures that they deem necessary throughout the testing procedure.

By signing this form I, _____ acknowledge that the risks and benefits of this test have been explained to me and I have full understanding of those risks and benefits.

Patient Printed Name

Patient Signature

Date

Witness Printed Name

Witness Signature