

**Chinook Lung Function Clinic
204 542 – 7 Street South
Lethbridge, Alberta
T1J 2H1**

Phone: **403-327-7675**

Fax: **403-327-7674**

PULMONARY FUNCTION REQUISITION

Patient Information:

Name: _____ Date Ordered _____

Date of Birth: _____ AHC # _____

BMI: _____ Male/Female Wheelchair bound Yes or No

Address: _____

Phone: _____

Cell Phone: _____

Reason for Test: _____

Current Medications: _____

Physicians information/Referring Doctor

Name: (print) _____ Prac ID #: _____

Clinic: _____

Address: _____

Phone: _____ Fax: _____

Physician Signature: _____

Pulmonary Function Procedure

Please check the procedure to be preformed

_____ Complete Pulmonary Function Test

Information sheet given _____

_____ Spirometry

Information sheet given _____

Required order by Physician with level IV Interpretation: Dr. E Wilde /Dr. L Oviatt

_____ CPET _____ Information sheet given _____

_____ Bronchial Provocation _____ Information sheet given _____

Requisition received _____

Lab use only _____

APPOINTMENT DATE: _____

TIME: _____