Health
South Eastern Sydney
Local Health District

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

THE SUTHERLAND HOSPITAL

REFERRAL – RESPIRATORY FUNCTION TEST

SES010415

Department Members: Drs Con Archis / Andrew Ng / Ben Kwan / George Hamor / Greg Katsoulotos

From Clinic / Ward: ……

or

Private Rooms (Address): ……

……

Reason for request:

Accurate DLco requires current Hb: _____(g/L)

Current Bronchodilators:

Previous respiratory function tests at TSH or SGH? ☐ **Year?**_____

Routine Studies

- ☐ Full lung function – spirometry, lung volumes, diffusion capacity (DLco)
- ☐ Spirometry – pre and post bronchodilator
- ☐ Airway Provocation using hypertonic saline (asthma challenge)

Special Studies *(specialist referral or consultation with lab staff required)*

- ☐ Exercise oximetry
- ☐ Respiratory Muscle Tests (*MIPs and MEPs*)
- ☐ Six Minute walk test
- ☐ Skin Prick Testing

Referring Doctor: ……

Address: ……

Provider No…… Phone/page: ……

Signature: …… Date: ……

Respiratory Function Laboratory: Telephone: 9540 7902 Fax: 9540 7093

Holes punched as per AS2828.1:2012
BINDING MARGIN - NO WRITING

REFERRAL – RESPIRATORY FUNCTION TEST

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