



FAMILY NAME

MRN

GIVEN NAME

MALE FEMALE

THE SUTHERLAND HOSPITAL

D.O.B. ____ / ____ / ____

M.O.

ADDRESS

**REFERRAL – RESPIRATORY
FUNCTION TEST**

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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

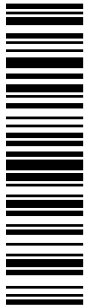
Referring Doctor:

Address:

Provider No..... Phone/page:

Signature: Date:

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



SES010415

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

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REFERRAL – RESPIRATORY FUNCTION TEST

SES010.415