NIAGARA PULMONARY
medicine & diagnostics

Niagara Pulmonary Medicine & Diagnostics
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Patient Information

Full Name: _____
Last *First* *M.I.*

Address: See ED face sheet. If not received by fax, please call ED
Street Address *Apartment/Unit #*

_____
City *Province* *Postal Code*

Home Phone: _____ Alternate Phone: _____

OHIP: _____

Request Information

Reason for Referral :

_____

_____

_____

Please check one:

☐ 1. **Consultation and FULL Pulmonary Function Testing** (pre and post bronchodilator, lung volumes, DLCO and oxygen saturation by pulse oximetry).

☐ 2. **Consultation only**

☐ 3. **Full Pulmonary Function Testing only** (spirometry, lung volumes, diffusion, pre and post bronchodilator)

☐ without post bronchodilator testing

☐ 4. **Spirometry only**

☐ without post bronchodilator testing

Referring Physician Information

Referring MD: _____ Address: _____

Signature: _____ _____

Billing Number: _____ _____

Date (dd/mm/yyyy): _____ Phone: _____

Cc: _____ Fax: _____