RESPIRATORY TEST REFERRAL

Client details	**Clinical Physiology**
FIRST NAME:	SURNAME:
ADDRESS	
DATE OF BIRTH	AGE SEX
TELEPHONE	HOSPITAL NUMBER
Ethnicity :	Iwi (if identified):
NZ Resident ☐ YES ☐	No. Occupation:
DATE OF REFERRAL / /	DATE TO BE TESTED / /
REFERRING DOCTOR	CONSULTANT
GP	COPIES TO

☐ SMOKER ☐ NON SMOKER ☐ EX SMOKER

INDICATION FOR TEST	**Ht** cm.	**PRIORITY**	
	Wt Kg.	Inpatient	
		Outpatient urgent 1 week	
CURRENT MEDICATION		Routine(2-3 wks)	
		Other	

☐ **Spirometry – Baseline** ☐ **Spirometry with reversibility** ☐ **Full Pulmonary function test (spirometry, diffusing capacity, lung volumes)** ☐ **Bronchial Challenge Test -** ☐ **Exercise** ☐ **Saline** ☐ **Arterial Blood Gas** ☐ **Other**	**SPIROMETRY RESULTS** **(pred.) pre post % change** **FVC** **FEV1** **%FEV1/FVC** **PEF**
Technician's report **Technician** **Test date** **Patient co operation** **Bronchodilator used** **Comments**	**Report**