

Carling Respiratory Services

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Respirology & PFT Referral

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REFERRING PHYSICIAN INFORMATION

Billing # Physician Name

Phone # Fax #

Address

PATIENT INFORMATION/STICKER

Patient Name

Email: _____

OHIP # VC

Address H#:

M#:

DOB (DD-MM-YY) Phone #

REQUISITION DETAILS

- Respirology Consultation** (for patients ≥ 18 y.o.)
- Includes pulmonary function testing (PFT) if indicated.

Please indicate urgency below:

- Routine
 Semi-urgent (*within 3 months*)
 Urgent (*within 1 month*) *additional info required

OR

- Pulmonary Function Testing only:** (select ≥ 1)
*Available for ages 7 and up

- Full PFT (Spirometry, lung volumes & DLCO)
 Spirometry pre & post bronchodilator
 Diffusion capacity & lung volumes
 Oxygen saturation by pulse oximetry
 Fraction Exhaled Nitric Oxide (FeNO) 100\$

REASON FOR REFERRAL (Required)

To ensure timely triage of this patient, please attach patient profile including updated medication list & all relevant notes/test results/imaging. Explain reasoning for Urgent referral requests.

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Visit us at:

www.carlingrespiratoryservices.com

