CLINIC REFERRAL FORM

MODERN LUNG DIAGNOSTICS

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Calgary, AB T2H 0G3

Ph: (587) 327-5081
Fax: (833) 297-8968
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Patient Information (Label may be attached)

Last Name: **First Name:** **PHN:**

DOB: **Sex at Birth:** ☐ Male ☐ Female **Preferred Pronoun:**

Phone (Daytime): (403) 123-4567 **Phone (Alternate):** **Email:**

Address:

Pulmonary Diagnostics

☐ **Pulmonary Function Test (PFT)**
Includes Pre-Spirometry, Post-Spirometry, Lung Volumes, & Diffusion Capacity

Spirometry

- ☐ Pre & Post
- ☐ Seated & Supine
- ☐ + Diffusion Capacity

☐ **MIPs/MEPs**

☐ **Methacholine Challenge**
Requires Respirology Consult

Consultation

☐ **Respirology Consult**
Requires Full Pulmonary Function Test*

**A recent PFT is required by the Respirologist. If testing has been done in the last 6 months, please attach a copy of the report. If there is no recent PFT, one will be scheduled for the patient.*

Referring Physician & Clinic Information (Clinic label may be attached)

Referring Physician: **PRAC ID:**

Clinic Name: ☐ **cc Physician:**

Address: **Phone:** **Fax:**

Physician Signature: **Date:**

Indication for Testing/Additional Comments

- ☐ **Dyspnea**
- ☐ **Query Asthma**
- ☐ **Evaluate Asthma**
- ☐ **Interstitial Lung Disease**
- ☐ **Evaluate COPD**
- ☐ **Query COPD**
- ☐ **Chronic Cough**
- ☐ **Pre-Operative**
- ☐ **Other**

Smoking Status

☐ **Non-Smoker** ☐ **Smoker** ☐ **Ex-Smoker**

If your office requires more requisition pads, and/or patient information sheets, please call our office or email us at info@modernlungdiagnostics.com. You can also download sheets from modernlungdiagnostics.com or scan the QR code →