





**Respirologists:**

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 1-587-393-3935

 RESPMD.COM

 1-855-933-2316

# REQUISITION FORM

Date: \_\_\_\_\_

## PATIENT INFO

(Please use address label with valid phone number)

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male:  Female:

Provincial Health #: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_

## OFFICE

Referring MD/NP: \_\_\_\_\_

Referring MD/NP Prac ID: \_\_\_\_\_

Referring MD/NP Signature: \_\_\_\_\_

Referring ph: \_\_\_\_\_

Referring fax: \_\_\_\_\_

Family MD/NP: \_\_\_\_\_

## TESTING REQUESTED

- FULL PULMONARY FUNCTION TESTING (includes Pre- and Post-Bronchodilator Spirometry, Diffusion, Lung Volumes)
- SPIROMETRY PROTOCOL (includes Pre- and Post-Bronchodilator Spirometry; MAY include Diffusion Capacity and Lung Volumes)
- MCT (METHACHOLINE CHALLENGE TEST)
- ARTERIAL BLOOD GAS
- Other: \_\_\_\_\_

### INDICATION FOR PULMONARY FUNCTION TEST

## CONSULTATION REQUEST

ADULT RESPIROLOGY

Next Available Physician OR \_\_\_\_\_  
(Specific Physician)

ADULT SLEEP MEDICINE ASSESSMENT (Full consultation and appropriate testing as required)

Next Available Physician OR \_\_\_\_\_  
(Specific Physician)

## REASON FOR CONSULTATION

(Please indicate reason or attach separate letter)

# OUR LOCATIONS:

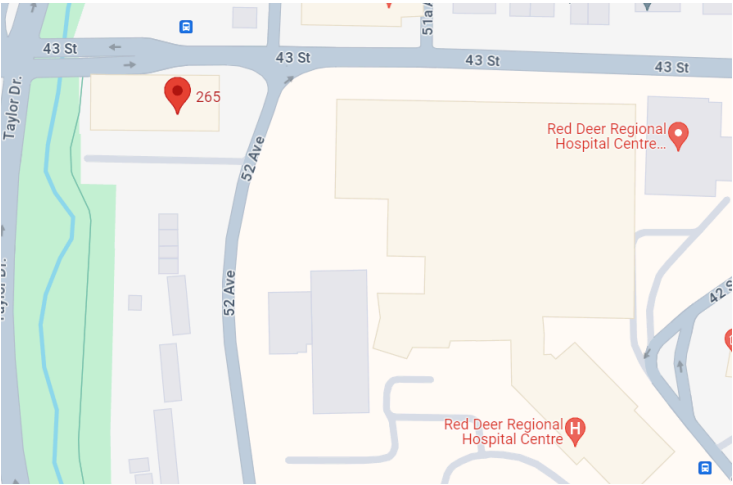
## CALGARY SW

850, 10655 Southport Rd SW  
Calgary, AB  
T2W 4Y1



## RED DEER

265 - 5201 43rd St.  
Red Deer, AB  
T4N 1C7



## COCHRANE

612 1st Street W,  
Cochrane, AB  
T4C 1B1

