CALGARY SW
850, 10655 Southport Rd SW
CALGARY NE
120, 2891 Sunridge Way NE

RespMD
RESPIRATORY+ SLEEP MEDICINE

RED DEER
265 - 5201 43rd St.
COCHRANE
612 1st Street W

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)