



Respiratory Therapy Diagnostic Services

Bookings (705) 328-6091 Fax (705) 328-6202

***** OUR DEPARTMENT WILL NEED *****

1. Your RMH hospital card.
2. Your Ontario Health card.
3. This form. **A signed requisition must accompany you for the test.**

WE ARE A FRAGRANCE FREE ENVIRONMENT - NO PERFUMES PLEASE

APPOINTMENT DATE: _____ TIME: _____

PATIENT NAME: _____ DOB: _____

PATIENT PHONE NUMBER: _____ OHIP #: _____

FAMILY DOCTOR: _____ DATE REFERRED: _____

Relevant History & Diagnosis:

Present Medications: (Please bring an updated list)

REFERRING DOCTOR: _____

PHYSICIAN'S SIGNATURE: _____

ALL OF THE ABOVE MUST BE COMPLETED AND SIGNED BY THE ORDERING PHYSICIAN

Pulmonary Function Test:

Ventolin will be given if indicated (unless otherwise specified).

- Full PFT** (includes SVC, FVL, SBD)
- Basic Spirometry** (includes SVC, FVL)
This test will be done on children 7 – 12 years.
Children under the age of 7 years will not be tested.
- Home O₂ Assessment**
(includes ABG's, Oximetry at rest and with exercise.)

Other

- ABG's**
- O₂ Saturation**
- Aerochamber Instruction**
- Peak Flows**

Oxygen Prescription

In the event a patient qualifies for Home Oxygen, they will be set up on liter flow of 2-4 LPM by the HME company of their choice.

PHYSICIAN'S SIGNATURE: _____