



FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____		M.O.
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility:

PULMONARY FUNCTION TEST REQUEST FORM

Additional patient details:

Contact Number: _____ Interpreter Required?: No or Language: _____

Indication for test: _____ Urgent (must specify reason)

Medical history:

- Chronic obstructive pulmonary disease
- Asthma
- Interstitial lung disease
- Neuromuscular disease
- Ischaemic heart disease
- Cardiac failure
- Pulmonary hypertension
- Neurological or cognitive disorder

Other relevant medical history:

Current inhaled medications:

Weight > 150kg If on bronchodilator: Withhold Continue

Standard testing

Specialised testing

- | | |
|--|---|
| <input type="checkbox"/> Full test "screening" (spirometry, volumes, DLCO) | <input type="checkbox"/> Maximum inspiratory/expiratory pressures |
| <input type="checkbox"/> Spirometry only (pre- & post-bronchodilator) | <input type="checkbox"/> Supine spirometry |
| <input type="checkbox"/> Fraction of exhaled nitric oxide (FeNO) | <input type="checkbox"/> Bronchial provocation (mannitol) |
| <input type="checkbox"/> Arterial blood gas – specify FiO2 | <input type="checkbox"/> Skin prick aeroallergen testing |
| <input type="checkbox"/> Six-minute walk test | <input type="checkbox"/> Other specialised test - _____ |

Referring Practitioner details: (Stamp if available)

Doctor: _____

Provider number: _____

Address (for results): _____

_____ Date: ____/____/____

Contact number: _____ Signature: _____

Respiratory Function Laboratory

Respiratory and Sleep Testing and Treatment, C2c, C-block, Nepean Hospital (see over for directions)
Phone: (02) 4734 1084 Fax: (02) 4734 1122

Email completed form to: NBMLHD-RespiratoryFunction@health.nsw.gov.au

BRING COMPLETED FORM WITH YOU ON THE DAY OF THE TEST



Holes Punched as per AS2828.1: 2019
BINDING MARGIN - NO WRITING

NBMHR-0227A 161225

PULMONARY FUNCTION TEST REQUEST FORM NBMHR-0227

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility:

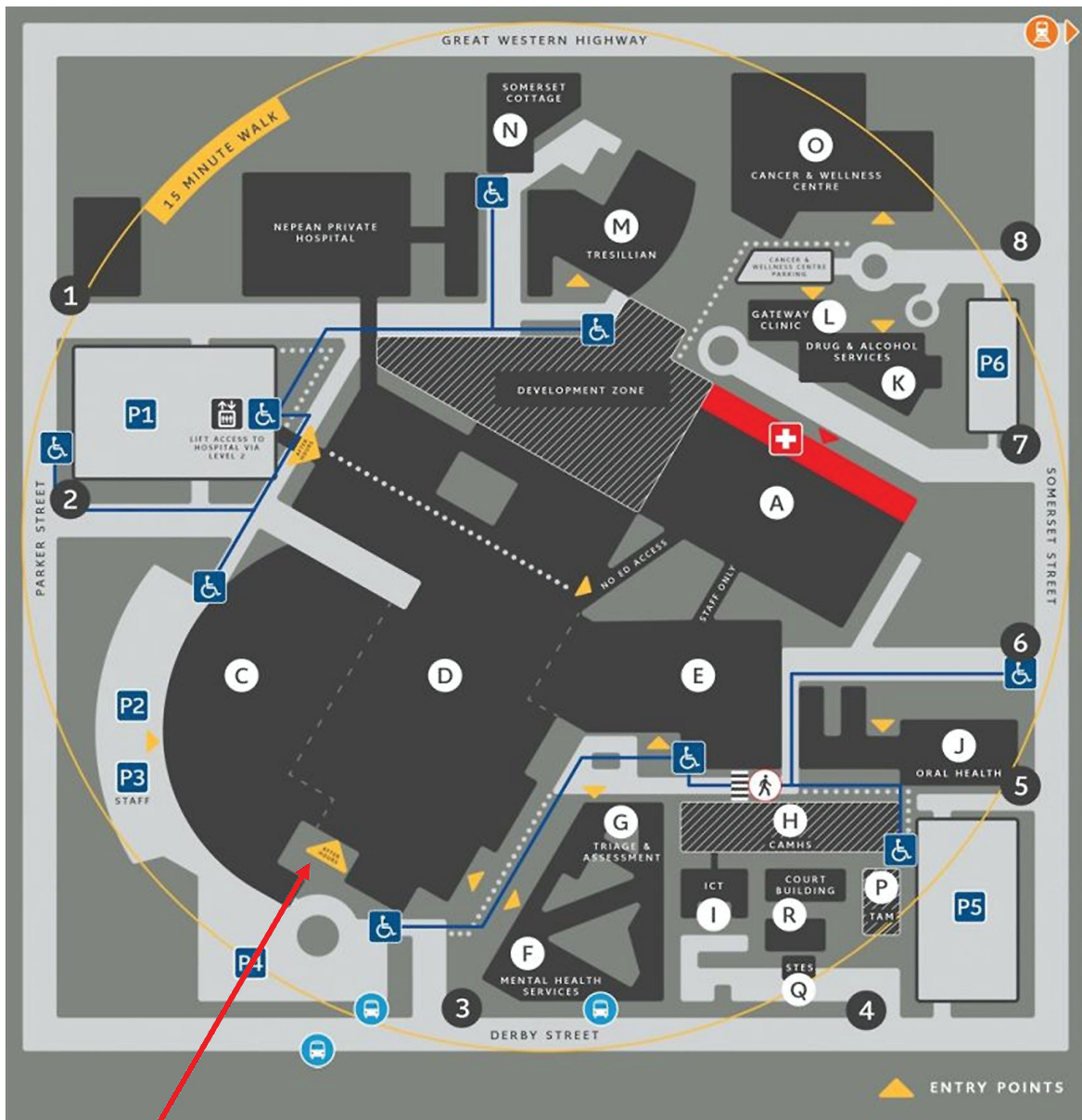
**PULMONARY FUNCTION TEST
REQUEST FORM**

Directions:

The best way to access C2c is via Derby Street (entrance 3 below).

After turning into the hospital from Derby Street (entrance 3), bear left following the road to the turning circle. The access to C2c towards the right from the turning circle.

Note: There is NO public access to C2c from within the hospital.



Entrance to C2c outpatients

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