Please PRINT Clearly. **Include info in CAPS.** **Fax to 416-469-7717**

Michael Garron Hospital
CHEST Centre
825 Coxwell Ave E
Toronto, ON, M4C 3E7
416 469 7777 (phone)
416 469 7717 (fax)
www.tehn.ca/respirology

Patient Information:
Name:_____
Date of birth (DD/MM/YY):_____
Address:_____
_____
HCN:_____VC:_____
Phone:_____
Mobile:_____
Email:_____

☐ **Telephone / Virtual Appointment Date and Time:**_____

☐ **In-person Appointment Date and Time:**_____

☐ **In-person Breathing Test (PFT) Appointment Date and Time:**_____

REASON FOR REFERRAL: _____
_____
_____
Medications: _____
_____
☐ Non-smoker ☐ Smoker _____pack years ☐ Quit date _____ ☐ Hemoglobin: _____

Respirology Consultation: ☐ First available ☐ Dr. D. Bain ☐ Dr. I. Fraser ☐ Dr. M. Kargel
☐ Dr. L. Kim ☐ Dr. A. Vagaon ☐ Dr. C. Walsh

Pulmonary Function Testing:
☐ **Flow volume loop** *(ie: for COPD follow-up)*
☐ **Pre and post bronchodilator Flow volume loop** *(ie: for asthma)*
☐ **Flow volume loop + Diffusion Capacity** *(ie: for COPD, lung cancer)*
☐ **Full PFT** (flow volume loop, lung volumes, diffusion capacity) *(ie: for COPD, interstitial lung disease),*
☐ **add post bronchodilator Flow volume loop**
☐ **Methacholine Challenge Test** *–Pre and Post bronchodilator spirometry required first*
☐ **Stage 1 Cardiopulmonary Exercise Test** *– Respirology consultation required first*
*Additional tests available with Respirology consultation

Clinical information (Required entry):
☐ Possible TB (or other infectious disease) ☐ Other:
☐ Recent hemoptysis
☐ Unstable angina or MI in past 3 months
☐ Aortic aneurysm, Brain aneurysm
☐ Recent eye surgery or uncontrolled glaucoma

"I agree that the above tests may be adjusted if needed depending on the clinical circumstances. Consultation or repeat referral may be required for additional testing."

Physician Signature: _____ Date: _____
Physician name (Print):_____ Billing #: _____
Tel: _____
Fax: _____