St. Joseph's Healthcare Hamilton

FIRH Firestone Institute for Respiratory Health

LABORATORY REQUISITION

Firestone Institute for Respiratory Health, St. Joseph's Healthcare Hamilton
Charlton Campus, Juravinski Innovation Tower, Level 1
50 Charlton Ave. E., Hamilton, ON L8N 4A6
Tel: 905-521-6000 Fax: 905-523-LUNG (5864)

Initial all applicable boxes and entries

Name: _____

Address: _____

City: _____

Postal Code: _____

Date of Birth: _____

Health Card Number: _____

Telephone Number: _____

FOR OFFICE USE ONLY

Appointment Date and Time:

Reason for Test(s): _____

Is this a WSIB claim? ☐ No ☐ Yes Claim Number: _____

Medications (respiratory and cardiac): _____

_____ (Ask patient to bring in all medications)

Hemoglobin: _____ g/L; Date measured: _____

Active Communicable Disease (e.g. TB): ☐ No ☐ Yes Specify: _____

☐ **Flow Volume Loop and Spirometry** (including FEV_1, VC and Flow Rates)
☐ Flow Volume Loops post bronchodilator

☐ **Pulmonary Function Study** (flow volume loops, lung volumes, single breath D_LCO, airways resistance, maximal inspiratory/expiratory pressures, oximetry if indicated) ☐ Post bronchodilator

☐ **Methacholine Challenge** (to assess bronchial hyper-responsiveness)
MUST HAVE a complete Pulmonary Function Test (PFT) / Spirometry performed and completed prior to testing - if PFT/spirometry results available they must accompany / fax with the requisition.

☐ **Allergy Skin Test** to Common Allergens (No antihistamines for 4 days)

☐ **Exercise Test** (progressive work on bicycle, flow volume loop, ECG, BP, heart rate and ventilation, VO_2, VCO_2, Oximetry)

☐ **6 Minute Walk Test on Room Air** (otherwise specify oxygen requirements): _____

☐ **6 Minute Walk Test Pulmonary Hypertension Clinic:** ☐ R/A ☐ Oxygen: _____

☐ **Home Oxygen Assessment** (includes oximetry at rest and assessment of exertional hypoxemia)
O_2 at 2-3 lpm or _____
- If resting SpO_2 is equal to or less than 88% perform ABG

☐ **Arterial Blood Gases**: ☐ Room Air ☐ Oxygen (lpm) _____
(If possible hold anticoagulants)

☐ **Sputum induction** ☐ **Spontaneous for:** ☐ Differential Cell Count ☐ Other: _____
☐ AFB: _____ ☐ Other: _____

☐ **Other:** _____

Physician's Printed Name: _____ Physician's Signature: _____

Phone/Fax Number: _____ CPSO Number: _____ Date Signed: _____