



Airway Clinic Diagnostics Referral Form

St. Mary's General Hospital
911 Queen's Blvd.
Kitchener, ON, Canada
N2M 1B2
Tel: 519.744.3311

PLEASE FAX REFERRAL FORM TO 519-749-6816

Please call the Airway Clinic at 519-749-6868 (option 1) if you have any questions or concerns

Patient Name: _____ HCN#: _____

Date of Birth: _____ Gender: Male Female

Parent Name (if applicable): _____

Address: _____

Phone (Home): _____ (Work): _____

Physician/Nurse Practitioner: _____ CPSO #: _____

Medication Instructions: Patient to hold inhalers day of test take inhales as prescribed

Reason for Referral:

Enable Diagnosis of a pulmonary disorder

Symptoms: _____

Follow up assessment. Current Diagnosis: _____

Other: _____

Procedure

Pulmonary Function Testing (must be \geq 12 years of age) includes spirometry, lung volumes, diffusion capacity, oxygen saturation, post bronchodilator testing if meets criteria
 post bronchodilator testing to be completed regardless of results

Spirometry Testing includes oxygen saturation, post bronchodilator testing if meets criteria
 post bronchodilator testing to be completed regardless of results

Arterial Blood Gases

Please indicate: Room Air On Oxygen _____ liters per minute

Cardio-Pulmonary Exercise Testing (C-PET) to be ordered by Respiriologists only

Individual Exercise Assessment for Home Oxygen to be ordered by Respiriologists only

6 Minute Walk Test to be ordered by Respiriologists only

Signature of Referring Provider: _____ Date: _____

Provider Address: _____

Provider Phone number: _____ Fax: _____

SMGH Airway Clinic Response:

Please notify your patient an appointment has been scheduled for:

Date: _____ Time: _____