RESPIRATORY SERVICES
REFERRAL FORM

PALMERSTON NORTH HOSPITAL

Telephone 350 8009 for appointment
Fax: 350 8647 Fax: 8647 (internal)

Referral initiated from COPD Pathway. Map of Medicine

Surname _____ Hosp no _____

First names _____ D.O.B. _____

Address _____ Ward/clinic _____

_____ Phone _____

Doctor/Nurse Practitioner _____ at _____

Copy to _____ at _____

Previous visit: Yes / No Inpt / Outpt

Infectious risk: Yes / No Specify _____

Diagnosis _____

Reason for test _____

_____

Smoker Y / N / Ex Pack years _____

Clinical details and medications:

Specific requirements: ☐ Wheelchair ☐ Oxygen cylinder
☐ Interpreter ☐ Comprehension concerns
☐ Other

Signature _____ Date _____

Pager _____

LUNG FUNCTION

- ☐ Spirometry
  - ☐ Pre/post Salbutamol
  - ☐ Pre/post Ipratropium
  - ☐ Inspiratory/Expiratory Loops
- ☐ Diffusing Capacity (DLCO)
- ☐ Lung Volumes (TLC) FRC Helium
  - ☐ RAW
- ☐ Oximetry
- ☐ Respiratory Muscle Strength (MIPS/MEPS/SNIP)
- ☐ FeNO
- ☐ Skin Prick Test for *Aspergillus Fumigatus*
- ☐ 6 Minute Walk Test
  - ☐ One Technician ☐ Two Technicians
- ☐ Provocation Challenge *(by arrangement with respiratory physician)*
  - ☐ Methachaline ☐ Mannitol ☐ Saline
- ☐ Cardiopulmonary Exercise Evaluation
  (by arrangement with respiratory physician)
- ☐ Sputum induction *(by arrangement with respiratory physician)*