

RESPIRATORY SERVICES

REFERRAL FORM PALMERSTON NORTH HOSPITAL

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



Previous visit: Yes / No

Weight Height.....

SURNAME _____ HOSP NO _____

FIRST NAMES _____ D.O.B. _____

ADDRESS _____ WARD/CLINIC _____

_____ PHONE _____

DOCTOR _____ at _____

COPY TO _____ at _____

LUNG FUNCTION

- Spirometry
 - Pre/post Salbutamol
 - Pre/post Ipratropium

Note: Please advise patient that inhaled bronchodilators should be withheld for 6 hours prior to spirometry.

Prescription for:

Salbutamol 2-5mg – 5mg via nebuliser

Ipratropium 0.5mg via nebuliser

To be administered stat. prior to commencement of spirometry

Signed _____

Date _____

Diagnosis _____

Smoker: Y / N / Ex

Clinical details and medication / Inhalers:

Signature _____ Date _____

Pager Number _____