

**LUNG FUNCTION TEST REQUEST FORM**

Patient’s name:………………………………………………………………………………...

DOB:………………………………………………………………………………………….

Address:……………………………………………………………………………………….

Contact number:………………………………………………………………………………

CLINICAL HISTORY/DIAGNOSIS:…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Smoking history:…………………………………………………………Hb………….……

Current inhaled medications:…………………………………………………………………

* Full Lung Function (includes spirometry, diffusion capacity, lung volumes)
* FeNO
* Spirometry (flow volumes loops – pre & post bronchodilator)
* Respiratory muscle tests ( MIPs & MEPs)
* Mannitol bronchial challenge
* ABG (arterial blood gas)

REQUESTING DOCTOR NAME:…………………………………………………………

Address:……………………….....................................................Provider no:…………………..

Signature:……………………………………………………..Date:………………………

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