



Patient Details:

Name: _____ Date of birth: ___/___/___
Address: _____
Phone: _____ E-mail: _____
Clinical history:

Consultation Requested:

- Respiratory
- Sleep

Investigation Requested:

- Full lung function tests (spirometry- before and after bronchodilator, lung volumes, gas transfer)
- Spirometry (Before and after bronchodilator)
- Bronchial Provocation Test (Mannitol Challenge Test)
- FENO (Fractional Exhaled Nitric Oxide – non-invasive measurement of airway inflammation)
- Respiratory Muscle Strength (MIPS/MEPS & Postural Spirometry)
- Level 2 home sleep study

Referring Doctor Details:

Name: _____ Provider Number: _____
Address: _____
Phone: _____ Fax: _____
Copy of report to _____

Signature: _____ Date of Referral: _____