Alexandra Marine and General Hospital
120 Napier Street
Goderich, ON N7A 1W5
T 519-524-8323 | **F 519-524-8532**

Cardiorespiratory Services Requisition

Patient Name: _____ Alternate Phone #: _____
Date of Birth (dd/mm/yyy): _____ Health Card #: _____
Telephone #: _____ WSIB#: _____
Patient will be notified by email, if email provided. Patient Email: _____
(Patient understands email may not allow secure communication)

Clinical Information _____

_____

Medication List (required): _____

_____

Pulmonary Function Testing

- ❑ **Full PFT** (refer to protocol): (Hemoglobin required for Diffusion)
  Pre/Post SABA (400mcg Ventolin) Spirometry, Volumes, Diffusion Hb ____, Airway Resistance, O_2 Saturation
  (No smoking, caffeine, or puffers 4-6 hours prior to test, bring puffers to test if available)
- ❑ **Spirometry Pre/Post SABA (400 mcg Ventolin)**: (for screening and/or follow-up)
  (No smoking, caffeine, or puffers 4-6 hours prior to test, bring puffers to test if available)
- ❑ **Spirometry Only** (No smoking, caffeine, or puffers 4-6 hours prior to test, bring puffers if available)
- ❑ **Arterial Blood Gases:**
  ❑ Room Air ❑ For Home O_2 ❑ On O_2____ L/m
- ❑ **Oximetry**
  ❑ At rest
  ❑ With exercise (6 minutes brisk walking – may include stairs)
  ❑ Overnight

Cardiology Test

- ❑ **Stress Testing (Stress Test Only - Internal Medicine consultation is not included if ordered on this form)**
  Please include relevant clinical information above. Includes Exercise Oximetry. Running shoes and medication list required. Ladies should wear a bra and a loose fitting, short sleeved blouse or t-shirt.
- ❑ **Ambulatory Blood Pressure Monitoring**:
  Instructions: Please wear a loose short sleeved top. Test is not covered by OHIP. You will be invoiced. Bring a medication list.
- ❑ **Electrocardiogram (ECG/EKG)**
  Instructions: Please don't use oils/powders on chest/arms/legs prior to testing.
- ❑ **Holter Monitor:** ❑**24hour** ❑**48hour** ❑**14 days**
  Instructions: Please don't use oils/powders on chest/arms/legs prior to testing. Ladies should wear a bra and a loose fitting blouse or t-shirt. Please bring medication list.

REFERRING PHYSICIAN:
Practitioner's Name (Print) _____ Address: _____

City: _____ Postal Code: _____ Tel: _____ Fax: _____

Physician's Signature: _____ Billing No: _____

Copy to: _____ Date: _____
(dd/mm/yyyy)