Respiratory Department
Pulmonary Function Test Request Form

BLACKROCK HEALTH
HERMITAGE CLINIC

Note to patients: Please arrive at least 10 minutes prior to your scheduled time to facilitate registration and please bring a list of current medications

PATIENT DETAILS

Name:_____

Address:_____

_____

Tel: _____

DOB: _____

Male ⃝   **Female** ⃝

REASON FOR THE TEST/CLINICAL QUESTION

_____
_____
_____
_____
_____
_____

TEST(S) REQUIRED (please tick)

Spirometry/Flow Volume Loop   ⃝

Reversibility (400mcg Salbutamol) or only if needed

Gas transfer (DLCO)   ⃝

Lung Volumes   ⃝

CURRENT MEDICATIONS

_____
_____
_____

Referring Physician   **Date**

_____   _____