

REFERRAL FOR LUNG FUNCTION TESTS

Please fax completed form to Mildura Base Public Hospital Ambulatory Care Department on 03 5022 3207

PATIENT DETAILS	SURNAME:	GIVEN NAME:
	DOB:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	ADDRESS:	TELEPHONE: _____
		MOBILE: _____
		WORK: _____
REFERRING DOCTOR	NAME:	
	PROVIDER NUMBER:	
	ADDRESS:	
	TELEPHONE:	
	EMAIL:	
INSURANCE STATUS	<input type="checkbox"/> INSURED <input type="checkbox"/> UNINSURED <input type="checkbox"/> DVA <input type="checkbox"/> DEFENCE <input type="checkbox"/> OTHER	
INDICATION(S) Please include any relevant clinical Information		
TESTS REQUIRED	<input type="checkbox"/> SPIROMETRY (includes pre and post bronchodilator testing)	
	<input type="checkbox"/> SPIROMETRY & DLCO	
	<input type="checkbox"/> LUNG VOLUMES	
DATE OF REQUEST: / / SIGNATURE OF REQUESTING DOCTOR:		
<p>TEST DESCRIPTION:</p> <p>Spirometry: A measure of airway function that includes parameters such as FEV1, FVC, FEV/FVC ratio and mid flow rates measured pre and post bronchodilator.</p> <p>Gas Transfer (diffusing Capacity): A measure of the lungs ability to transfer gas from the alveoli into the blood stream. Includes parameters such as DLCO, KCO AND VA.</p> <p>Lung Volumes: A measure of various volumes and capacities of the lungs useful in determining restriction, hyperinflation and gas trapping. Parameters include TLC, FRC and RV.</p>		