# LUNG FUNCTION REQUEST

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**PATIENT DETAILS (BLOCK LETTERS)**

SURNAME: _____

GIVEN NAMES: _____

ADDRESS: _____

_____ POSTCODE: _____

TELEPHONE: _____

DATE OF BIRTH: _____

**DOCTOR (NAME, ADDRESS, TEL, PROVIDER No.)**

COPY TO:

**LUNG FUNCTION STANDARD TEST**

☐ **SPIROMETRY/FLOW VOLUME STUDY & DIFFUSING CAPACITY (DLCO) eg. asthma/COPD/emphysema**

Other tests available

☐ SPIROMETRY & LUNG VOLUMES. eg. restriction, rarely indicated

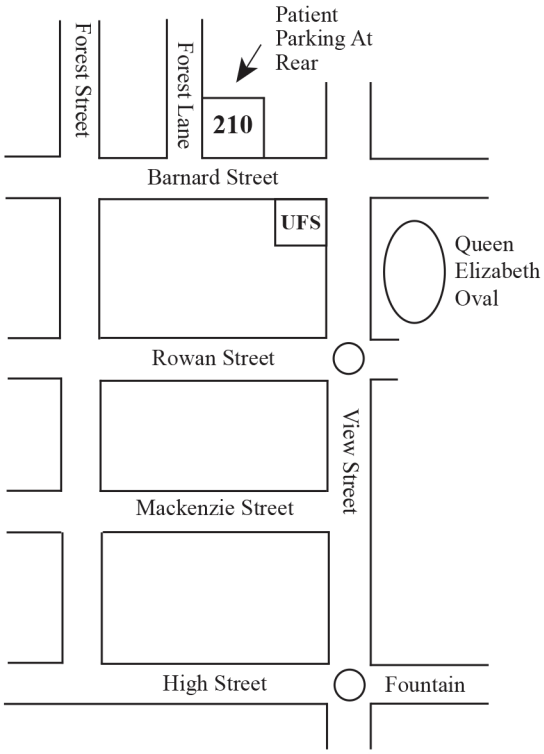
☐ SPIROMETRY FLOW / VOLUME STUDY. eg. upper airway obstruction

☐ **REFERRAL FOR PHYSICIAN ASSESSMENT & MANAGEMENT**

**CLINICAL NOTES:**

SIGNED: DATE:

**PATIENT INSTRUCTIONS OVERLEAF**




## PATIENT INFORMATION

- If possible, avoid all inhaler medications for 4 hours prior to the test
- Avoid smoking if possible
- Please note the time that asthma medication was last used
- Please bring a list of current medications each visit

**Your next appointment:**

**Date:** _____

**At:** _____

_____

_____

**Failure to attend without adequate notice may incur a fee.**