Alexandra Hospital Ingersoll
Tillsonburg District Memorial Hospital
Partnering to keep healthcare close to home.

RESPIRATORY DIAGNOSTIC REQUISITION

Tillsonburg District Memorial Hospital
TDMH Scheduling/Bookings Contact:
Phone: 519-842-6335 Fax: 519-842-4299

Referring Physician or Other Authorized Health Care Provider

Name (Please Print): _____

Phone: _____ Fax: _____

Provider Billing #: _____

Provider Signature: _____

Copy to: _____

Date of Referral: _____
(YYYY/MM/DD)

Patient Information:

Name (Last, First): _____

Date of Birth (DOB): _____ ☐ Male ☐ Female
YYYY MM DD

Personal Identification Number (PIN): _____

Address: _____

Phone Number (Home): _____

(Other): _____

Health Card Number: _____ Version Code: ____

Smoking History:

☐ Non-Smoker

☐ Smoker: # Years smoked: _____

# of cigarettes per day (maximum): _____

☐ Ex-Smoker: Quit Date (yyyy/mm/dd): _____

# of cigarettes per day (maximum): _____

Relevant Patient History:

Examination:

☐ Spirometry – Oximetry
- ☐ Post Bronchodilator required

☐ Full Pulmonary Function Test (PFT) includes: Spirometry – Airway Resistance, Lung Volumes, Diffusion Capacity and Oximetry
- ☐ Post Bronchodilator required

☐ Arterial Blood Gases (ABG)

Contraindications:

Please note, exam will be cancelled if:

- Recent heart attack (within 4 weeks)
- Recent surgery of eye, chest or abdomen (within last 6 weeks)
- Acute respiratory illness (within last 2 weeks)
- Active or suspected tuberculosis
- Patient is under 14 years of age

UNSIGNED, INCOMPLETE REQUISITIONS WILL BE RETURNED AND APPOINTMENTS WILL NOT BE BOOKED UNTIL A SIGNED AND COMPLETED REQUISITION IS RECEIVED.