THE ASTHMA AND RESPIRATORY HEALTH CENTRE

Medical Director: Dr Raymond Gottschalk
Respirologist: Dr Marina Lerner

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PATIENT INFORMATION:

First name: _____ **Last name:** _____

Email address (for patient instructions): _____

Gender: [ ] M [ ] F Date of Birth: _____/_____/_____
dd / mm / yyyy

Address: _____

Phone (Day):_____ (Home): _____ (cell):_____

OHIP#: _____ Version Code: _____

Referring Physician Information:

First/Last Name: _____ Phone: _____ Fax: _____

Address: _____

Physician OHIP #: _____ _____Physician email:_____

Clinical Diagnosis: [ ] Asthma [ ] COPD [ ] ILD [ ] Other:

Clinical Information: [ ] Smoker [ ] Ex-smoker _____ Pack Years [ ] Life-time non-smoker

Hgb: _____g/L date _____ Respiratory inhaler/meds:_____

[ ]Sleep Apnea: AHI _____(if known); O2 desaturations lowest on PSG/ overnight O2_____%

On O2: [ ] _____*l/ minute*

Reasons for tests: [ ]Diagnosis [ ]Follow-up [ ]Baseline measurement [ ]Other:

Test(s) Requested: please check off all those required: **Urgent [ ] Routine [ ]**

(Note: In order to obtain reliable results, patient must be able to follow verbal instructions.)

[ ] Spirometry [ ] Lung Volumes [ ] Diffusion Capacity [ ] MIPS [ ] MEPS

[ ] Full PFTs (all of the above)

[ ] Oxygen Saturation at rest

[ ] Exercise stress test

Please note that patients check in at 55 Frid Street, The Hamilton Sleep Disorders Clinic. Plentiful parking is available.