Cardio/Respiratory
Diagnostic Testing

REFERRAL REQUISITION

Appointment Date/Time: ______________________

Bookings for Pulmonary Function Test/Electroencephalogram/Holter Monitoring/Echocardiography
Telephone: **807-684-6680** / Fax: **807-684-5907**

Bookings for Cardiac Stress Test
Telephone: **807-684-6322** / Fax: **807-684-5907**

Guidelines:
1. Physician to complete requisition. Incomplete requisitions will be returned resulting in delay of study.
2. **Requisition is to be faxed to the Booking Clerk**.
3. All **Regional referrals** are to be **faxed to** the **Regional Booking Office** at **807-684-5907**.
4. Since a procedure cannot be done without a completed and signed requisition, a requisition must be received by the Booking Clerk at least 48 hours in advance of the test or the appointment will be rebooked / cancelled.
5. Completed requisitions will be filed in the Booking Office.
6. Please be sure to give the patient the appropriate patient information sheet.

Clinical Diagnosis: ______________________ **Possible TB?** ☐ **Yes** ☐ **No**

Pertinent Clinical Findings: ______________________

Relevant Therapy Medications: ______________________

Do you want a copy of the report to be sent to the Family Physician? ☐ **Yes** ☐ **No**

PULMONARY FUNCTION TEST

Hemoglobin: ______ Height ______ Weight: ______

- ☐ Full Pulmonary Function Test
- ☐ Spirometry Only
- ☐ Methyl Choline Challenge
- ☐ Oximetry Resting/Walking
- ☐ Arterial Blood Gas
- ☐ Maximum Inspiratory Pressure /Maximum Expiratory Pressure
- ☐ Cardiopulmonary Exercise Test
- ☐ Home Oxygen Assessment

CARDIAC STRESS TEST

- ☐ Regular Stress Test
- ☐ Cardiolite Stress Test
- ☐ Persantine Stress Test
- ☐ Dobutamine Stress Test
- ☐ Modified Stress Test
- ☐ Stress Echo

ECHOCARDIOGRAM

- ☐ Complete
- ☐ Limited
  Specify:____________________
- ☐ Transesophageal (TEE without consult)
- ☐ TEE with consult

ELECTROENCEPHALOGRAPHY

- ☐ Routine Electroencephalogram
- ☐ Routine Sleep Deprived Electroencephalogram
- ☐ Routine Electroencephalogram with Sleep

HOLTER MONITORING

- ☐ 24 Hour Holter
- ☐ 48 Hour Holter
- ☐ Loop Recorder

Physician's Name: ______________________
(please print)

Physician's Signature: ______________________ **Date**: ______________________