TASMANIAN HEALTH SERVICE

Tasmanian Government

LUNG FUNCTION REQUEST
RESPIRATORY

PT ID									

SURNAME .... D.O.B. ....

OTHER NAMES ....

ADDRESS ....

Attach Patient Sticker Label

FACILITY: ______________________

Southern Region

WELLINGTON CENTRE		
Telephone:	6166 0000 (Bookings)	6166 0042 (Technician)
Fax: 6234 3982	Email: rhhrfulab@ths.tas.gov.au	

TEST REQUESTED ***(tick box):***

Test	
Spirometry	☐
Diffusion Capacity	☐
Arterial Blood Gases	☐

INSTRUCTIONS TO PATIENTS FOR RESPIRATORY FUNCTION TESTS

1. Before your appointment do not take the following for the times indicated unless absolutely necessary:

a) Short acting inhalers (puffers) or nebulisers (salbutamol, terbutaline, ipratropium, sodium cromoglycate) — 8 Hours
b) Long-acting inhalers — 24 Hours
c) Antihistamines — 72 Hours
d) Caffeine containing products — 4 Hours

2. Exercise testing requires loose clothing suitable for cycling (no skirts/dresses)

COMPLEX TESTING – only performed in consultation with Respiratory Physician and/or selected cases ***(tick box):***

Test			
Static Lung Volumes	☐		
Bronchial Provocation Test	☐		
Oxygen Walk Test	☐		
Cardiopulmonary Exercise Test	☐		
High Altitude Simulation Test	☐		
Maximal Respiratory Pressures	☐		
Other *(specify below):*	☐		

CLINICAL NOTES:

REPORT DESTINATION ***(print):***

Specialist and unit:	Ward:
General Practitioner:	Fax no:
Additional report to:	

REQUESTING DOCTOR:

Print name:	**Designation:**
Signature:	**Date:**
Provider no:	

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