Grand River Community Health Centre

Spirometry Referral Form

Please fax this form to 519-754-0757

Grand River Community Health Centre
363 Colborne St, Brantford, ON, N3S 3N2
Phone: 519-754-0777 Fax: 519-754-0757

Patient Information/Sticker:

Referral Request:

☐ SPIROMETRY
Pre-post bronchodilator

Or

☐ SPIROMETRY
Without bronchodilator

Medical History:

Smoking	☐ Yes	☐ No	
Bronchodilator	☐ Yes	☐ No	
Steroid Therapy	☐ Yes	☐ No	
Home Oxygen	☐ Yes	☐ No	_____L/minute
Antihistamine	☐ Yes	☐ No	
Beta-blocker	☐ Yes	☐ No	
Recent Hospitalization /illness	☐ Yes	☐ No	

Clinical Information:

Diagnosis: _____

Booking Timeframe:

☐Next Available ☐ Not before: _____

Indication for Test:

☐Objective Assessment/ Diagnosis
☐Pre/Post-op Assessment
☐Guide to Treatment
☐Chemotherapy/ Amiodarone
☐Routine Follow-up
☐Other: (Please Explain)

Contraindications to testing:

Please assess all contraindications before sending the referral. Select "None of the Above" if none apply.

- No verbal consent from client
- Someone who has shown hypersensitivity to any of the ingredients contained in salbutamol
- Spirometry should be deferred for those who have a major viral or bacterial infection, those who are experiencing symptoms that may interfere with their test performance i.e. nausea, vomiting, respiratory infection and or difficult taking a full breath due to injury/discomfort
- Recent surgery within the last 4-6 weeks (including eye surgery)
- Significant glaucoma
- Increased sinus and middle ear pressure
- Pneumothorax
- Pregnancy
- Systemic hypotension or severe hypertension
- Significant Atrial/ventricular arrhythmia
- Recent MI, stroke or pulmonary embolism (in the last 3 months)
- History of syncope to forced exhalation/cough
- Active TB
- Hepatitis B
- Hemoptysis or oral bleeding
- Recent head injury or concussion
- Aneurysm – cerebral, thoracic, or abdominal

☐ **None of the Above**

☐ Previous spirometry report attached ☐ No spirometry reports available
☐ Client MUST be prescribed Salbutamol if doing pre/post (if not prescribed, no post bronchodilator test will be done)

MD/ND Name: _____ Billing Number: _____

Address: _____ City/Town: _____ Postal Code: _____

Clinic Phone: _____ Clinic Fax: _____

Signature: _____ Date of Request: _____