

**Scarborough North Pulmonary Services
SCARBOROUGH NORTH MEDICAL ARTS**

(BASEMENT) 4040 FINCH AVENUE EAST, SUITE LL5 (MEDICAL LAB)

SCARBOROUGH, ONTARIO M1S 4V5

Tel: (416) 335-6735 Fax: (416) 292-5814

Web: snpulmonaryfunction.ca Email: snpfungtesting@gmail.com

PATIENT'S LAST NAME (PLEASE PRINT OR TYPE)	INITIALS

PATIENT'S FIRST NAME (PRINT)	PATIENT'S BIRTH DATE	SEX
	DAY MONTH YEAR	M F

ADDRESS

POSTAL CODE	PHONE HOME OFFICE
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HEALTH CARD NUMBER

| | | | - | | | - | | | | VC | | | |

**FIRST CALL (416) 335-6735
FOR APPOINTMENT**

APPOINTMENT DATE _____

DIAGNOSIS/CLINICAL HISTORY

SMOKER YES NO HOW LONG? _____ YEARS HOW MUCH? _____ PK/DAY

S T U D I E S	<p>PLEASE CHECK BOXES</p> <p><input type="checkbox"/> FLOW-VOLUME LOOPS <input type="checkbox"/> DIFFUSION CAPACITY</p> <p><input type="checkbox"/> LUNG VOLUMES <input type="checkbox"/> OXYGEN SATURATION AT REST</p> <p><input type="checkbox"/> FULL PULMONARY FUNCTION TEST (INCLUDES ALL ABOVE)</p> <p> ↳ <input type="checkbox"/> BRONCHODILATOR IF FEV1/FVC \leq 70% OR \leq LOWER LIMIT OF NORMAL</p>
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REFERRING PHYSICIAN

NAME	PHONE NUMBER
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ADDRESS

DATE	SIGNATURE
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COPIES TO

PLEASE GO DIRECTLY TO FRONT DESK!
MAP ON BACK PAGE

PLEASE GIVE THIS FORM TO PATIENT