Winnipeg Lung Diagnostics

REFERRAL FORM

2-230 Osborne St. R3L 1Z5 Winnipeg, MB
Ph: (204) 818-1564
Fax: (204) 410-7090

PATIENT DEMOGRAPHICS

Name: _____ Gender: _____

Address: _____

PHIN (9-Digit): _____ MHSC (6-Digit): _____

Date of Birth: _____ Email: _____

Phone: (Work) _____ (Home): _____ (Cell): _____

REASON FOR TESTING

- ☐ Asthma
- ☐ COPD
- ☐ Shortness of Breath
- ☐ Other _____

TESTS AND SERVICES REQUESTED

- ☐ Full Pulmonary Function Test
- ☐ Full Pulmonary Function Test (With Bronchodilation)
- ☐ Spirometry
- ☐ Spirometry (With Bronchodilation)
- ☐ 6 Minute Walk Test (6MWT)
- ☐ Other _____

ADDITIONAL PATIENT INFORMATION

Smoking Hx:

- ☐ Non-Smoker
- ☐ Ex-Smoker
- ☐ Current Smoker
  - ➢ If yes, packs/day: _____

CLINIC REFERRING PHYSICIAN

Clinic Name: _____

Phone: _____

Fax: _____

Family Physician: _____

Referring Doctor : _____
(Please Print)

Signature:

FOR OFFICE USE ONLY

Test Performed:	Pre:	Post:
Spiro	☐	☐
Lung Volumes	☐	
Diffusion Capacity	☐	
6 Minute Walk Test	☐	

Comments: _____

Please fax the completed form to (204) 410-7090.
We will contact the patient for booking.

Version 2.0