# Canadian Central Medical Referral Inc.

**SERVING SCARBOROUGH & GTA EAST**

## RESPIRATORY & PFT

**Please fill in all information and e-mail or fax to our office. Patients will be contacted directly.**

**E-mail: referrals@medreferral.ca  Toll Free Fax: 1-855-566-8498  Toll Free Phone: 1-855-434-7373**

### 1. Referring Physician

Physician's Name: _____

Signature of Referring Physician: _____

Date of Request: _____

Billing No: _____

Address: _____

Telephone: (_____)_____ Fax: (_____)_____

### 2. Patient Information

Last: _____

First: _____

D.O.B: _____ ☐ Male ☐ Female

Health Card No: _____ VC: _____

Address: _____ Postal Code: _____

Phone (H): (_____)_____ (W): (_____)_____ (C): (_____)_____

E-mail: _____

### 3. Services Requested (please check all that apply)

☐ Respirology Consultation
(Please provide recent blood work, chest X-Ray, CT/MRI reports)
☐ PFT with consultation
☐ PFT only
☐ Full Pulmonary Function Test (PFT) includes:
- ☐ Spirometry
- ☐ Spirometry Post-bronchodilator
- ☐ Lung Volumes
- ☐ Diffusion capacity (DLCO)
- ☐ Resting Oximetry

☐ Spirometry (FVL) Only
☐ Spirometry Post-Bronchodilator
☐ Oximetry
- ☐ Resting
- ☐ Exercise (6-minute walk)

☐ Other: please specify

### 4. Clinical Information (Required)

Reason for Referral:

Pertinent Medical History:

Smoking History:
☐ Non-Smoker
☐ Smoker
Years Smoked: _____ # Cigarettes/Day (max): _____
☐ Ex-Smoker
Quit Date: _____ Years Smoked (max): _____ # Cigarettes/Day (max): _____

Medications:

Allergies:

CONTRAINDICATIONS FOR PFT TESTING: Severe aortic stenosis, Recent Pneumothorax, Active TB, Severe or unstable angina, Anginal pain at rest or on exertion not relieved by nitro spray, Myocardial infarction < 4 weeks, Current acute febrile Respiratory illness, Significant active hemoptysis (coughing up frank blood), Advanced pregnancy (near term), Recent eye/abdominal surgery.

### 5. Special Patient Needs

☐ Wheel-Chair Patient ☐ Oxygen ☐ Accompanied by Attendant
☐ Language ☐ Additional Comments: _____

Received Date: Appointment Date: Time:

☐ Cancellation Policy Notified to Patient - Please give us a 2 business days notice if you are unable to keep this appointment. Otherwise, a no show fee will apply.

This requisition form can be taken to any licensed facility providing health care services including hospitals accepting community referrals and community surgical and diagnostic centres, such as those listed on the website: https://www.ontario.ca/page/community-surgical-and-diagnostic-centres

***Rev. 2025/03/25***