TRI-FACILITY
SPIROMETRY CLINIC REFERRAL
Musquodoboit Valley Memorial Hospital
Tel: 902-717-7596; Fax 902-425-4191

Patients Name ______________________________

Patient Address ______________________________

Date of Birth ____________________ Health Card # ____________________

Best Daytime Contact Number ______________________________

- **Children under 16 years old please refer to IWK for Spirometry**

Referring: ______________________________

Date: ______________________________

SERVICE REQUESTED

☐ Spirometry. Reason for testing: ______________________________

A Bronchodilator will be given unless otherwise indicated by the referring provider

Yes	No	
		1. Has the patient ever had a previous spirometry test?
		2. Previously treated with oral steroids?
		3. Are they currently taking puffers? If yes, please list.
		4. Is the patient a smoker? If patient ever smoked, date quit:
		5. How many exacerbations have occurred in the past year? _____ Treated by physician? (ER/GP)
		6. Diagnostics : ☐ CT ☐ chest x-ray

* Please complete all fields as required for triage.*

* Patients with obstruction on spirometry may be contacted for education pending a diagnosis of COPD from their primary care provider.

Comments:

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Updated February 27, 2024