

- DR. JAMES ROBERTSON  
Respiratory & Sleep Physician
- DR. JACK HERON  
Consultant Nephrologist
- DR. NICHOLAS SHARROCK  
Geriatrician

## **OPEN ACCESS RESPIRATORY FUNCTION TESTING REFERRAL**

Please fax or email through the referral to our rooms and we will contact your patient to make an appointment. Thank you.

Patient name:	
Patient DOB:	
Patient address:	
Phone:	

### **Respiratory studies required:**

- |   |   |
|---|---|
| <input type="checkbox"/> Complex lung function (complete lung assessment) | <input type="checkbox"/> Bronchial Provocation Test |
| <input type="checkbox"/> 6 minute walk test                               | <input type="checkbox"/> Body Plethysmography       |
| <input type="checkbox"/> On room air                                      |   |
| <input type="checkbox"/> On oxygen  |   |
| <input type="checkbox"/> MIP & MEP – Respiratory muscle strength          |   |

Clinical notes/medications:
-----------------------------

Referring doctor:		
Provider No:		
Practice Address:		
Practice email:		
Copies to:		
Signature:		Date: