Respiratory Dynamics

18035 107th Avenue NW
Edmonton, AB
T5S 1K3
Tel: (780) 244 - 7377
Fax: (780) 249 - 7377

RESPIRATORY SERVICE REQUISITION FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Sex: _____

Address: _____ Phone: _____

Diagnosis: _____ ULI: _____

RESPIRATORY SERVICES

☐ **Pulse Oximetry/Respiratory Assessment**
☐ At Rest ☐ On Exertion

Oxygen Therapy
☐ Keep SpO2 > 90%
☐ Flow Rate _____ LPM

☐ **Arterial Blood Gas** (Spirometry Included)

☐ **Pulmonary Function Test**

☐ **Spirometry Only**

☐ **Pulmonary Consult**

PHYSICIAN SIGNATURE

Referring Physician: _____ Physician Signature: _____

Physician Phone #: _____ Physician Fax #: _____

Additional Comments: _____

_____