Quarterly Spirometry Report

Please submit a minimum of 5 spirometry tests for review per quarter. These samples must be de-identified by removing or blacking out any patient identifying information.

Please submit spirometries to your contact within Regional Respiratory Therapy via fax with a cover page and this report.

Along with this report please submit your Spirometer Quality Control Log.

Spirometries Conducted*

Month	Number of Pre-/Post-Bronchodilator Spirometries Completed	Number of Pre-test Only Spirometries Completed	Number of Spirometry Samples Submitted

*Note: Clinicians performing spirometry are requested to perform 5 or more per month in order to maintain skills. If you are having trouble achieving this number, please contact Regional Respiratory Therapy.

Name of Tester_____

Testing Site_____

Date of Submission_____