SEVEN OAKS
General Hospital
2300 McPhillips Street, Winnipeg, Manitoba R2V 3M3

REQUISITION FOR DIAGNOSTIC SERVICES

PATIENT NAME _____ ☐ MALE ☐ FEMALE

ADDRESS _____
POSTAL CODE

BIRTH DATE _____ M.H.# _____ P.H.I.N.# _____

TELEPHONE HOME _____ BUSINESS __

HOSPITAL USE ONLY

DATE

TIME

ACCOUNT NO.

CLINICAL HISTORY/DIAGNOSIS _____

PHYSICIAN'S NAME (PLEASE PRINT CLEARLY) _____

PHYSICIAN'S SIGNATURE _____ DATE _____

NOTE: PATIENT TO ARRIVE AT REGISTRATION OFFICE 30 MINUTES PRIOR TO APPOINTMENT.
OUT-PATIENT SERVICES AVAILABLE MONDAY – FRIDAY EXCLUDING STATUTORY HOLIDAYS.

RESPIRATORY THERAPY

PHONE: 204-632-3621
FAX: 204-632-8896
(9:00 a.m. – 4:00 p.m.)

*** APPOINTMENT REQUIRED**
BRONCHODILATOR NOT TO BE TAKEN 4 HOURS PRIOR TO TEST.

PLEASE CHECK DESIRED TESTS
- ☐ SPIROMETRY BEFORE BRONCHODILATOR
- ☐ SPIROMETRY AFTER BRONCHODILATOR
- ☐ ARTERIAL BLOOD GAS
- ☐ LUNG VOLUMES (FRC, RV, TLC, RV/TLC)
- ☐ LUNG DIFFUSION
- ☐ ASTHMA CHALLENGE (Histamine)

APPOINTMENT _____ DATE _____ TIME

DIAGNOSTIC IMAGING SERVICES

(8:00 a.m. – 4:00 p.m.)

PHONE: 204-632-3239 - X-RAY, ULTRASOUND, C.T. SCAN
204-632-3285 - NUCLEAR MEDICINE

SEE REVERSE FOR PREPARATION

EXAMINATION REQUESTED

1. X-RAY _____
2. ULTRASOUND _____
3. NUCLEAR MEDICINE _____

APPOINTMENT _____ DATE _____ TIME

CARDIOLOGY

PHONE: 204-632-3239 (8:00 a.m. – 4:00 p.m.)

☐ STANDARD TRACING

*** APPOINTMENT REQUIRED**
- ☐ STRESS TESTING
- ☐ HOLTER MONITORING

APPOINTMENT _____ DATE _____ TIME

NOTE: STRESS TESTING REQUESTS REQUIRE A CONSULTATION BY A PHYSICIAN FROM THE DEPT. OF MEDICINE

4. C.T. SCAN _____

IS THIS REQUEST?
- ☐ ELECTIVE
- ☐ URGENT
- ☐ EMERGENT

FORWARD THIS FORM TO C.T. SCAN DEPARTMENT. DO NOT SEND TO REGISTRATION OFFICE. YOU WILL BE NOTIFIED OF APPOINTMENT DATE AND TIME FOLLOWING REVIEW BY A RADIOLOGIST.

LABORATORY

PHONE: 204-632-3238 (8:00 a.m. – 6:00 p.m.)

SEE LAB INFORMATION MANUAL FOR FASTING & TESTS REQUIRING APPOINTMENTS.

EXAMINATION REQUIRED

☐ CBC	☐ GLUCOSE	☐ TRIGLYCERIDE
☐ PT	☐ CREATININE	☐ NA.K.CL.
☐ URINALYSIS	☐ UREA	☐ TOTAL PROTEIN
☐ PTT	☐ CHOLESTEROL	☐ URIC ACID

OTHER _____

WHITE – HEALTH RECORDS YELLOW – DIAGNOSTIC SERVICES PINK – PHYSICIAN BUFF – PATIENT

GRACE HOSPITAL

RESPIRATORY THERAPY DEPARTMENT

PULMONARY FUNCTIONS REQUISITION

(Please phone for an appointment)

Phone: (204) 837-0590

Fax: (204) 837-0510

Name _____ Address _____

Phone _____ D.O.B. _____ Personal Health I.D. # (9 digit) _____

Dr. _____ Appointment _____

DIAGNOSIS _____

SMOKING Hx _____

Symptoms: (Circle) Cough Sputum Wheeze Dyspnea Chest Pain

PREVIOUS LUNG SURGERY: Lobectomy _____ Pneumonectomy _____ Other _____

HEIGHT _____ WEIGHT _____ SEX _____ AGE _____

Please check desired tests:

	PRE	POST BRONCHODILATOR
Spirometry, FVC, FEV, /FVC	_____	_____
Flow Volumes, PEFR, MEFR50	_____	_____
Lung Volumes, TLC, FRC, RV & airway resistance	_____	_____
Diffusion Capacity	_____	Medication _____
		Dose _____

Gas Exchange & Exercise Testing

Blood gas on room air_____or % O_2 _____

Progressive exercise test _____ With 0_2 saturation

Other tests _____

Physician's Signature _

Hôpital St-Boniface Hospital

PULMONARY FUNCTIONS REQUISITION

NAME: _____

ADDRESS: _____

TELEPHONE #: _____

MHSC#: _____

ENC#: _____

DOB: _____

PHYSICIAN: _____

PULMONARY FUNCTIONS LAB
ST. BONIFACE GENERAL HOSPITAL
2C - 409 TACHE AVE.
WINNIPEG, MANITOBA
R2H 2A6
TELEPHONE # 237-2752
FAX # 235-3563

PLEASE CALL THE LAB AT 237-2752 TO SCHEDULE AN APPOINTMENT, THEN FAX THE COMPLETED REQUISITION TO 235-3563.

DATE & TIME OF APPOINTMENT: _____

DIAGNOSIS & REASON FOR TEST:

_____

_____

_____

CURRENT MEDICATIONS:

_____

_____

_____

Please circle the number(s) of the test(s) you are requesting

1. Complete Pulmonary Functions *(includes spirometry, lung volumes, diffusing capacity)*

2. Spirometry *(FVC, FEV1)*
Give Bronchodilator with above test q Yes q No

3. 6 Minute Walking Oximetry q Room Air ***or*** q Oxygen @_____L/min

4. Arterial Blood Gas q Room Air ***or*** q Oxygen @_____L/min

5. Asthma Assessment
- If asthma suspected, do you want bronchodilator given? q Yes q No
- If asthma suspected and there is no bronchodilator response, do you want a methacholine challenge? q Yes q No

6. Special Test(s) - _____
(please write the test[s] wanted)

A Respirologist must be consulted if you want either of the following:

7. Progressive Exercise Test

8. Walking Oximetry for Home O2 Assessment

Date Faxed: _____ Physician's Signature _____

WINNIPEG CLINIC

PULMONARY FUNCTIONS TESTING REQUISITION AND CHARGE SLIP

7th Floor 425 St. Mary Ave.
Winnipeg, MB, R3C 0N2

PHONE: (204) 957-3321
FAX: (204) 957-7410

NAME _____

ADDRESS _____

PHONE _____

D.O.B. _____

PHIN No. _____

MHSC No. _____

DR. _____

APPOINTMENT _____

Please check desired tests:

☐ **Simple Spirometry**
(FVC, FEV1, FEV1/FVC)
This test is done as a walk-in. Patient presents this requisition signed by physician.

☐ **Complete Pulmonary Functions**
(Spirometry, Flow Volumes, Lung Volumes, Diffusion capacity)
Appointment needs to be booked by phone & requisition faxed.
Doctor's office responsible for informing patient.

☐ **Progressive Exercise***
(Spirometry, Flow Volumes with O2 saturation & cardiopulmonary exercise stress)
Appointment needs to be booked by phone & requisition faxed.
Doctor's office responsible for informing patient.

☐ **Exercise Provocation Testing***
(Spirometry, Flow Volumes with O2 saturation & cardiopulmonary exercise stress)
Appointment needs to be booked by phone & requisition faxed.
Doctor's office responsible for test instructions and informing patient.

☐ **Oxygen Saturation Check**

☐ **Blood Gas on Room Air**

** Test requires running on a treadmill at an incline, therefore appropriate footwear required.*
Please inform your patient to arrive 5 minutes prior to their appointment.

Physicians Signature _____

Office use only:

☐ 8810	☐ 8850	☐ 8836	☐ 2300	☐ 8842
☐ 8815	☐ 8851	☐ 8854	☐ 40,000	
☐ 8820	☐ 8852			
☐ 8830				

Health Sciences Centre
Winnipeg

Adult Chest Medicine

PULMONARY FUNCTION TESTING

RS-211, Respiratory Hospital
810 Sherbrook Street
Winnipeg, Manitoba R3A 1R8
Phone: (204)787-1234 Fax: (2104)787-1333

DATE HSC NO.
PATIENT
DOB
PHIN #
DOCTOR
CLINIC/UNIT LOC'N

The following information must be filled and faxed, or mailed, to the Pulmonary Function Laboratory prior to the actual booking. This information is essential to ensure patient safety.

DIAGNOSIS: _____ **PRECAUTIONS:** _____

HEART DISEASE: ❑ **Yes** ❑ **No**

- ❑ Chest Pain - Undiagnosed
- ❑ Angina
- ❑ Recent Myocardial Infarction (< 6 months)
- ❑ Old Myocardial Infarction (> 6 months)
- ❑ Congestive Heart Failure
- ❑ Valvular disease – Specify _____
- ❑ Cardiomyopathy
- ❑ Hypertension
- ❑ Arrhythmias
- ❑ Pacemaker
- ❑ Implanted Defibrillator
- ❑ Other – Specify _____

MEDICATIONS:

- ❑ Beta Mimetics (Ventolin)
- ❑ Anticholinergics (Atrovent)
- ❑ Inhaled Steroids
- ❑ Oral Steroids
- ❑ Anti-Leukotrienes
- ❑ Digitalis
- ❑ Antiarrhythmics
- ❑ Calcium Channel Blockers
- ❑ Beta Blockers
- ❑ Other – Specify _____

SPIROMETRY AND LUNG VOLUMES	**Pre Bronchodilators**	**Post Bronchodilators**
1. Spirometry ($FEV_{1.0}$, FVC, Ratio)	❑	❑
2. Flow Volumes (PEFR, MMEF, FEF_{25}, FEF_{50}, etc.)	❑	❑
3. Lung Volumes (TLC, FRC, RV, Airway Resistance)	❑	❑
4. Diffusing Capacity	❑	
5. Maximum Inspiratory & Expiratory Pressures	❑	
6. Single Breath Nitrogen Washout	❑	

GAS EXCHANGE AND CARDIOPULMONARY EXERCISE TESTING

1. Arterial Blood Gas on Room Air	❑
2. Steady-State Gas Exchange on Room Air at Rest	❑
3. Calculation of Shunt on 100% Oxygen	❑
4. Walking Oximetry on Room Air	❑
5. Walking Oximetry on Oxygen	❑
6. Progressive Cardiopulmonary Exercise Testing	❑

ASTHMA CHALLENGE

1. Methacholine	❑
2. Cold Air	❑
3. Post Exercise	❑

Concordia HOSPITAL

1095 Concordia Avenue, Winnipeg, MB R2K 3S8

Requisition for Outpatient Diagnostic Service

Hours of Service

Monday to Friday – 9:00 a.m. to 3: 00 p.m.

No weekend or statutory holiday outpatient services.

Legal surname	First name	Initial	Name used	☐ Male ☐ Female

Birthdate Day Month Year	Manitoba Health no.	PHIN	Phone (home)	Phone (business)

Address	City, Postal Code

Clinical History / Diagnosis

Method of Payment: ☐ Self ☐ WCB # _____ ☐ Out of Province # _____

Please report to Admitting for the test[s] indicated below.

☐ Laboratory Phone: 661-7174 (9:00 a.m. to 3:00 p.m.)

No appointment required.

Examination required: [*indicates fasting required]

☐ CBC	☐ INR	☐ NA, K, Cl
☐ Urinalysis	☐ APTT	☐ Cholesterol
☐ Urine C&S	☐ Urea	☐ Triglyceride*
☐ Glucose*	☐ Creatinine	☐ Lipoprotein Profile*

☐ Other: _____

Glucose Tolerance Test* ☐ 3 hour ☐ 4 hour

Appointment Date: _____ Time: _____

Please call the Lab at 661-7174 to make an appointment.

☐ Respiratory Therapy Phone: 661-7346 Fax: 661-7234 (9:00 a.m. to 3:00 p.m.)

Bronchodilator not to be taken for 4 hours prior to test.

Examination Requested:

☐ Spirometry before bronchodilator Appointment Date: _____ Time: _____ Please call to make an appointment.

☐ Spirometry after bronchodilator Appointment Date: _____ Time: _____ Please call to make an appointment.

☐ Arterial Blood Gas Appointment Date: _____ Time: _____ Please call to make an appointment.

☐ Test[s] completed Therapist:

☐ Cardiology Phone: 661-7173 (9:00 a.m. to 3:00 p.m.)

No appointment required.

☐ Standard Tracing

☐ Test[s] completed Tech:

To expedite reporting, please print clearly. All fields must be completed.

Physician's Name	Office Phone Number
Office Address	Office Fax Number
Physician's Signature	Date

Chart Copy