Lung Function Request

RB&HH SPECIALIST CARE
Royal Brompton & Harefield Hospitals

77 Wimpole Street | Outpatients and Diagnostics
Tel: 020 7351 8186 | **Email:** rbh-tr.diagnosticwimpole@nhs.net

Patient Information

Hospital number: ....

Title: .... Surname: ....

Forename(s): ....

Address: ....

.... Postcode: ....

Date of birth: ___/___/___

Gender: ☐ Male ☐ Female

Contact Tel: ....

Mobile No.: ....

Email: ....

Interpreter required: ☐ Yes ☐ No Language: ....

Appointment Booked: ___/___/___ Time: ....

Payment Details

Payment Method: ☐ Insurance ☐ Embassy ☐ Self-Funding

Payment Provider: ....

Requested Respiratory Procedure

☐ Spirometry

☐ Gas Transfer

☐ Static Lung Volumes (Plethysmography)

Bronchodilator response: ☐ Ventolin ☐ Atrovent

☐ End Capillary Blood Gases

☐ Cardiopulmonary Exercise Test (Please complete contraindications on reverse side of form)

If other tests required please specify:

....

Additional Information

Patient transport: ☐ Walking ☐ Wheelchair ☐ Bed

Infection Risk: ☐ Yes ☐ No Details: ....

....

Allergies: ....

Pregnant: ☐ Yes ☐ No

Oxygen: ☐ Yes ☐ No

Asthma: ☐ Yes ☐ No

Beta Blockers: ☐ Yes ☐ No

Recent syncope: ☐ Yes ☐ No

Diabetic: ☐ Yes ☐ No Controlled by: ☐ Diet ☐ Tablets ☐ Insulin

Recent surgery: ☐ Yes ☐ No

Please specify surgery: ....

Please complete if Spirometry requested

Relative Contraindications:

Haemoptysis of unknown origin: ☐ Yes ☐ No

Recent pneumothorax: ☐ Yes ☐ No

Recent myocardial infarction: ☐ Yes ☐ No

Pulmonary embolism: ☐ Yes ☐ No

Thoracic, abdominal or cerebral aneurysms: ☐ Yes ☐ No

Recent eye surgery; raised intra-ocular pressure: ☐ Yes ☐ No

Recent thoracic or abdominal surgical procedures: ☐ Yes ☐ No

Cervical neck problems: ☐ Yes ☐ No

Any other physical problem: ☐ Yes ☐ No

Clinical Indication for Examination

Please summarise relevant history, clinical findings and previous test results.

....

Please indicate the question that the examination aims to answer: ....

....

Referrer name: ....

GMC: ....

Address: ....

.... Postcode: ....

Tel: ....

Email: ....

N.B. This form is a legal document – Referrer's Declaration

The correct patient details have been provided. I have discussed the examination, including any intervention with the patient / guardian. I have taken into account the possibility of pregnancy. I have given sufficient clinical information for the request to be justified according to IR(ME)R 2000 (if applicable). I will ensure that the examination results are recorded in the patient's notes.

Signature:

Date: ___/___/___

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Please complete if Cardiopulmonary Exercise Test requested

Absolute Contraindications:

Aortic Aneurysm:	☐ Yes	☐ No
Current viral illness/acute infection:	☐ Yes	☐ No
Unstable angina/acute ECG changes of ischaemia/acute cardia event:	☐ Yes	☐ No
Myocardial infarction within the last 4 weeks:	☐ Yes	☐ No
Severe hypertension (systolic >240mmHg; diastolic >120mmHg):	☐ Yes	☐ No
Poorly controlled heart failure:	☐ Yes	☐ No
Myocarditis/endocarditis:	☐ Yes	☐ No
Exacerbation of asthma:	☐ Yes	☐ No
Severe aortic stenosis:	☐ Yes	☐ No
Acute pulmonary embolus/thrombus/ venous thromboembolic disorders:	☐ Yes	☐ No

Relative Contraindications:

Gross arrhythmias:	☐ Yes	☐ No
Resting tachycardia >120 beats/min:	☐ Yes	☐ No
Electrolyte disturbance:	☐ Yes	☐ No
Epilepsy/cerebrovascular disease:	☐ Yes	☐ No
Resting PaO2 < 7.0kPa:	☐ Yes	☐ No
Pulmonary hypertension:	☐ Yes	☐ No
Uncontrolled metabolic disorders:	☐ Yes	☐ No
Advanced or complicated pregnancy:	☐ Yes	☐ No