Ridgeway
RESPIRATORY SERVICES

HEALTH AND SLEEP CLINIC REQUEST FORM

Name:
Address:

Postcode: DOB:
Hospital No: GP:

Home No: Mobile:

Consultant:
Shelburne Hospital ☐
Chiltern Hospital ☐
Other - please state:

Date of Request:
Book: in months/weeks ☐

Reason for request (Clinical details):

Smoking history:

CXR appearances:

Current medication:

Haemoglobin: gm/dL on (Date)

Any known infection risk?

CONTRAINDICATIONS TO TESTING:

Some procedures demand hard effort from the patient. The conditions listed below should be considered and balanced against clinical need for the results:

- *Haemoptysis of unknown origin*
- *Pneumothorax*
- *Unstable cardiovascular status, recent myocardial infarction or pulmonary embolus*
- *Thoracic, abdominal, or cerebral aneurysms*
- *Recent eye surgery (eg. cataract)*
- *Presence of an acute disease process that might interfere with test performance (eg. nausea, vomiting)*
- *Recent surgery of thorax or abdomen*

RESPIRATORY INVESTIGATION

Spirometry ☐

Full lung function study ☐
(Spirometry / F/V Loops, Gas Transfer, Lung Volumes)

Reversibility - MDI + Spacer ☐
NB: MDI = Salbutamol 500μg

FeNo measurement ☐

Respiratory Muscle Test ☐
(Standing/Supine, MIPs & MEPs)

Allergy Test ☐
(Skin prick method)

EXERCISE

6 Minute Walk Test ☐

SLEEP STUDIES

Domicillary Overnight Oximetry Study ☐

Other tests - Please specify:

PLEASE SEND REQUEST TO:

The Shelburne Hospital (Fax - 01494888701)
admin@ridgewayrespiratoryservices.co.uk

OFFICE USE ONLY

Received:
Appointment Date/Time:
Letter sent: ☐
DNA/Canc.

Doctor requesting test - Signed: Name: