Beacon Hospital

RESPIRATORY REFERRAL FORM

TEL: 01 2936694. FAX : 01 2936653.

PATIENT DETAILS

Male ☐ Female ☐

Surname

Forename

D.O.B.

Address

Tel. No.

DOCTOR'S DETAILS

Referring Doctor

Tel. No.

Fax

Surgery Address

MEDICAL INSURANCE

Company: Plan: Policy No:

PATIENT STATUS

OPD ☐ IP ☐ Ward Room No:

EXAMINATION REQUIRED *(ALL FIELDS ARE COMPULSORY. PLEASE NOTE INCOMPLETE FORMS WILL BE RETURNED)*

PFT's

- Spirometry ☐
- Diffusion ☐
- Lung Volumes ☐
- Reversibility ☐
- Respiratory Muscle Strength (Mips/Meps) ☐

Procedure Code

Clinical Reason for Test

Relevant History

Medications

Other Tests

- PSG Sleep Study (can only be referred by a Respiratory Consultant) ☐
- Limited Sleep Study ☐
- Overnight Oximetry ☐
- CPAP Titration (can only be referred by a Respiratory Consultant) ☐
- Cardiopulmonary Exercise Test (can only be referred by a Respiratory Consultant) ☐
- Mannitol Challenge Test (can only be referred by a Respiratory Consultant) ☐
- 6 Minute Walk Test ☐

DEPARTMENT USE ONLY

Requested By

Tel No.

Date

STICK ADDRESSOGRAPH HERE