Dr Hannes J van Rensburg
MB ChB (UFS), Mmed (Int) (UFS), FCCM
Internis / Specialist Physician
PR No: 1808486

Lung Function Test Request Form

PATIENT INFORMATION

Medical Aid _____ Number _____

Surname _____ Name _____

Sex _____ DOB _____ Phone _____

Address _____

REASON FOR REFERRAL

COPD — Suspected — Documentation of severity of condition

Chronic cough

Breathlessness

Other - Where response to therapy is not satisfactory (including asthma)

PHYSICIAN REMINDER
Please remind patients to withhold any breathing medications for 12 hours if pre and post spirometry measurements are required.

CLINICAL INFORMATION

Smoking history — Current — Ex Smoker - pack years for current/ex smokers _____ — Never Smoked

Clinical History _____

TEST/S REQUIRED

Standard Test
(Overall assessment of lung function includes spirometry, gas transfer and lung volumes)

Spirometry Only
(Airway function assessment)

Diffusing Capacity (DLCO)

Bronchial Challenge
(Airway sensitivity measurement)

Six Minute Walk Test

TEST DESCRIPTION

Spirometry:
A measure of airway function that includes parameters such as FEV1/FVC ratio and mid flow rates - measured pre and post bronchodilator.

Gas Transfer (Diffusing Capacity)
A measure of the lung's ability to transfer gas from the alveoli into the blood stream. Includes parameters such as DLCO, KCO and VA.

Lung Volumes
A measure of various volumes and capacities of the lungs useful in determining restriction, hyperinflation and gas trapping. Parameters include TLC, FRC & RV.

Bronchial Challenge
A measure of airway hyperresponsiveness after inhalation of increasing doses of a challenge agent. Useful in determining the presence of asthma or the effectiveness of asthma therapy. Parameters include serial measurements of FEV1, as a representation of airway narrowing. Please note: Good quality spirometry MUST be performed on a separate occasion so as to determine that a Bronchial Challenge can be conducted safely.

APPOINTMENT DETAILS

Please phone Tel 021 840 6809 to make an appointment

Day & Date _____

Time _____

REFERRING DOCTOR'S DETAILS

Name _____

Phone _____ ICD 10 _____

Email _____

Doctor's Signature — Date