



**RESPIRATORY FUNCTION TEST
REFERRAL FORM**

Dr Roger K. A. Allen MBBS (Hons 1ST Qld), FRACP, FC.C.P., PhD. (Melb).
Suite 46, Level 4, Wesley Medical Centre, 40 Chasely Street, Auchenflower, Qld 4066.
Phone: 3719 5577 Fax: 3719 5177 (ABN: 53 006 461 730)
e-mail: respiratorylab@internode.on.net Website: www.sarcoidosis.com.au & www.sleephealth.com.au

PATIENT DETAILS

DATE: _____

Name: _____

Address: _____

DOB: _____

TEST/S REQUIRED

- SPIROMETRY
- FLOW VOLUME LOOPS
- MANNITOL (ARIDOL) CHALLENGE
(Cannot be done at the same time as CO-transfer)
- LUNG VOLUMES AND CO TRANSFER FACTOR
- RESPIRATORY/ SLEEP CONSULTATION
- SLEEP STUDY

CLINICAL DETAILS

REFERRING DOCTOR (Must be completed)

Doctor's Name: _____

Provider No.: _____ Date: _____

Address: _____

Signature: _____

- () Fax report () Email report () Mail report
No. _____ () Report with Patient () Urgent