MIRA HEALTH CENTRE
#103A, 11910 - 111 AVENUE
EDMONTON, AB T5G 0E5
TEL: 780-452-1465 FAX: 780-452-8639
EMAIL: lunglabservices@gmail.com

PATIENT INFORMATION:

Last Name:______________________________ First Name: ______________________ ☐ Male ☐ Female

Address: ____

City: ________________________ Province: __________________ Postal Code: ________

Home Phone: ______-______-______ Cell Phone: ______-______-______

Date of Birth: ______-______-______ Personal Health Number: __________-__________
Month Day Year

REQUISITION FOR:

☐ Complete Pulmonary Function Test
☐ Flow Volume Loop (Pre & Post Bronchodilator Only)
☐ Oximetry - At Rest
☐ Flow Volume Loop (Pre Bronchodilator Only)

SYMPTOMS/CURRENT HISTORY:

☐ COPD ☐ Asthma ☐ Fibrosis ☐ Other:
☐ Dyspnea ☐ Cough ☐ CHF

SPECIFIC INSTRUCTIONS/COMMENTS:

____
____
____
____

PHYSICIAN INFORMATION:

Referring Physician:________________________ Signature: ____________________

Date: ______-______-______
Month Day Year

Telephone Number: ____________________ Fax Number: ______________________