BLACKROCK HEALTH
HERMITAGE CLINIC

Respiratory Department

Pulmonary Function Test Request Form

Note to patients: Please arrive at least 10 minutes prior to your scheduled time to facilitate registration and please bring a list of current medications

PATIENT DETAILS

Name:_____

Address:_____

_____

Tel: _____

DOB: _____

Male ◯ **Female** ◯

REASON FOR THE TEST/CLINICAL QUESTION

_____
_____
_____
_____
_____
_____

TEST(S) REQUIRED (please tick)

Spirometry/Flow Volume Loop ◯

Reversibility (400mcg Salbutamol) or only if needed

Gas transfer (DLCO) ◯

Lung Volumes ◯

CURRENT MEDICATIONS

_____
_____
_____

Referring Physician

_____

Date

_____

Hermitage Clinic
Respiratory Department
Ground floor
Old Lucan Road
Dublin 20
Tel: 01 645 9853
E: respiratory@hermitageclinic.ie