Tel: (01) 645 9853

Test Date: _____

Respiratory Department

Test Time: _____

Patient Name:

Address:

Hospital No.:

DOB:

Age:

Inpatient / Outpatient:

Tel Home:

Tel Mob.:

VHI / BUPA / ESB / Garda / Other: _____

Policy No.: _____

Plan: _____

For Technician's Use Only:

Height: _____

Weight: _____

Test Required *(Tick box)*

1. ☐ Spirometry
2. ☐ Spirometry with reversibility
3. ☐ Lung Volumes
4. ☐ Diffusion Capacity (DLCO)
5. ☐ Other *(please specify)* _____

Clinical Notes / Symptoms:

Referring Phsician *(Printed)*: _____

Signature: _____

All patients: Please bring your insurance details *(policy number and plan)* with you on the day of the test and any medications/inhalers you are currently taking