Community Provider Spirometry Referral form

PATIENT DETAILS

Referral Date: / / / / /

D.O.B: _____

Surname: _____ First Name(s): _____

NHI No.: _____ Ethnicity: _____ Iwi (if identified): _____

Address : _____

Other Contact details: Home: _____ Work: _____

Mobile: _____ Fax: _____

Email: _____ NZ resident: ☐ Yes ☐ No

Occupation: _____

GENERAL PRACTITIONER INFORMATION

HPI No.: _____ Medical Council Number: _____

GP Name: _____

GP Practice: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

Referral to

☐ Approved General Practice (listed on Bay Navigator)

Practice name _____

Fax Number _____

☐ Mobile respiratory Nurse -Whakatane

☐ Mobile respiratory Nurse -Kawerau

☐ Mobile respiratory Nurse -Opotiki

☐ PHO service

☐ Other _____

Note: If spirometry or additional testing is required at local Hospital Respiratory Laboratory, use the Respiratory Physiology Referral form available in Referral and Claims Forms on Bay Navigator

Reason for Referral

☐ **COPD** ☐ Suspected ☐ Documentation of current severity

☐ **Chronic cough**

☐ **Breathlessness** Where response to therapy is not satisfactory(including asthma)

☐ **Other**

Clinical information

Smoking history: ☐ Current ☐ ex Smoker – pack years for current/ex smokers _____ ☐ Never smoked

Long Term Classification	**Relevant Medications and dosage**

Bronchodilator response testing **

☐ Pre/post salbutamol (400 mcg, 4 puffs of MDI via spacer) To obtain accurate results , bronchodilator medications should be withheld.

***** Note** – once this prescription has been activated through **signing**, this form will become a legal prescription. If you do not wish to test bronchodilator response please cross out above prescription.*

G.P signature _____ NZMC No. _____

- For referral to **Approved General Practice** – see BayNavigator for Provider fax number.
- For referral to the mobile respiratory nurse:

  Whakatane - Fax …… Kawerau - Fax …… Opotiki - Fax……