

The London Clinic
Lung Function Laboratory
Cardiology Department
5 Devonshire Place
London W1G 6HE

Outpatient appointments T: 020 7616 7664
Fax: 020 7616 7688

Patient details: Mr/ Mrs/ Miss/ Ms

Surname: _____ **Forename:** _____ **DOB:** _____

Requesting Clinician: _____

Address for report: _____

Fee to be charged to: Patient Company Doctor

Test Required (please tick box):

Includes:

- | | | |
|---|---|--|
| <input type="checkbox"/> Routine Spirometry | SVC/FVC/FEV1/PEF | |
| <input type="checkbox"/> Routine Spirometry + Reversibility | Please tick box for inhaler: | <input type="checkbox"/> Ventolin
<input type="checkbox"/> Atrovent |
| <input type="checkbox"/> Full Lung Function | Routine Spirometry + Flow Volume Loop + KCO/
DLCOSB/RV/ TLC / ITGV | |
| <input type="checkbox"/> Full Lung Function + Reversibility | Please tick box for inhaler: | <input type="checkbox"/> Ventolin
<input type="checkbox"/> Atrovent |
| <input type="checkbox"/> CO transfer studies | KCO / DLCOSB | |

Clinical details: _____

Is the patient at risk?: YES / NO (If yes please give details) _____

Is the patient currently taking Beta-Blockers? YES / NO (If yes please give details)

Known Hb level _____ **Date of last blood test done** _____

Signature of requesting Clinician: _____ **Date:** _____

(Please note this form must be signed to administer inhaler)