

Moorabbin Specialist Consulting Centre

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**Southern Region
Respiratory Service**

Web: www.srrs.com.au

APPOINTMENT DATE: _____ **TIME:** _____

Please bring your Medicare or Veterans' Affairs Card

PATIENT DETAILS

Name: _____

Address: _____

D.O.B: _____ Sex: _____

Phone: _____

Patient Requires: Test Only

Subsequent Consultation (Referral letter required)

TESTS REQUIRED

- Spirometry—Pre & Post Bronchodilator
No Ventolin / Bricanyl / Atrovent for 4 hours prior to test. No Seretide / Serevent / Spiriva / Symbicort for 12 hours prior to test.
- Diffusing Capacity (DLCO)
No smoking for 4 hours prior to test.
- Skin Prick Testing
No antihistamine for 3 days prior to the test.
- Maximal Inspiratory & Expiratory Muscle Pressures
- Bronchial Provocation Challenge Test**
**Only available after discussion with physicians below.
- Educational Videos

REQUESTING DOCTOR

Name: _____

Address: _____

Signature: _____

Date: _____

Fax Results: Mail Results:

Ring Results: Email Results:

ARGUS Email Address: _____

CLINICAL DETAILS

Does the patient have (or is suspected of having) TB, HIV, Hepatitis, Cystic Fibrosis or Pseudomonas infection?

YES NO

(Tests will **NOT** be performed if not completed)

DR. Peter McLaughlin F.R.A.C.P.

A / Prof. Peter Holmes F.R.A.C.P., F.C.C.P.

