THE LONDON CLINIC

Lung function request

PATIENT INFORMATION

*indicates mandatory fields

*TLC unit no. (if known) L

*Title

*DOB dd/mm/yyyy)

*Surname

*Forename(s)

*Gender M F

IP OP DC

Room

*Referrer's full name and / or practice stamp

Payment method ☐ Insurance ☐ Embassy ☐ Self-Pay ☐ Sponsor

Payment provider

Member no.

Authorisation no.

Patient's tel no.

Patient's email

Patient's address

Copy of reports to

Tests required (please tick box)	Includes
☐ Routine Spirometry	SVC/FVC/FEV1/PEF
☐ Routine Spirometry + Reversibility	Please tick box for inhaler: ☐ Ventolin ☐ Atrovent
☐ Full lung function	Routine Spirometry + Flow Volume Loop + KCO/DLCOSB/RV/TLC/ITGV
☐ Full lung function + Reversibility	Please tick box for inhaler: ☐ Ventolin ☐ Atrovent
☐ CO transfer studies	KCO/DLCOSB

CLINICAL INFORMATION

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 ___/___/___

Please not that we will be unable to administer an inhaler unless this form is signed by the referring clinician.

Referring Clinician

Referrer's signature Date ___/___/___

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B **THE DUCHESS OF DEVONSHIRE WING**
22 Devonshire Place
London W1G 6JA

C **CARDIOLOGY DEPARTMENT (LUNG FUNCTION LABORATORY)**
Lower Ground Floor
5 Devonshire Place
London W1G 6HL

D **CONSULTING ROOMS**
145 Harley Street
London W1G 6BJ

E **PATHOLOGY SERVICES AND CONSULTING ROOMS**
120 Harley Street
London W1G 7JW

F **CONSULTING ROOMS**
116 Harley Street
London W1G 7JL

G **EYE CENTRE AND CONSULTING ROOMS**
119 Harley Street
London W1G 6AU