C-diagnostics (a division of C-health)
Suite 210, 1016 - 68 Avenue SW
Calgary, AB T2V 4J2
Ph: (403) 541-0033 Fx: (403) 541-0032
www.c-health.ca

DIAGNOSTIC SERVICE REQUISITION
PEDIATRICS

PATIENT INFORMATION (attach patient label)

Patient Name: ☐ M ☐ F
ULI: DOB:
Address: Postal Code:
City, Province: Home phone:
Email:

Referral Date: _____

☐ URGENT TESTING REQUESTED

Parent/Guardian Name: _____ Relation to Patient: _____

Contact No: _____

Respiratory History:

Check all that apply:

☐ RSV ≤ 1yr ☐ Respiratory-related Hospitalization(s) ☐ Known Asthma ☐ Recurrent Croup ☐ Premature Birth

Additional History & Notes:

Reason for Referral:

_____
_____
_____

PULMONARY DIAGNOSTIC SERVICES

☐ Spirometry Only (Age 5+)
  ☐ Include Medication/Inhaler Education & Review
☐ Pulmonary Function Test (Age 10+)
  ☐ Include Medication/Inhaler Education & Review

REFERRING PHYSICIAN INFORMATION

Referring Clinic: _____
Phone: _____ Fax: _____
Physician Name: _____
PRAC ID#: _____

Referring Physician Signature: