

SOUTH EAST ESSEX PRIMARY CARE TRUST

OPEN ACCESS SPIROMETRY SERVICE

REQUEST

TELE NUMBER (01702) 313600

FAX NUMBER (01702) 508514

NAME

ADDRESS

HOSPITAL NUMBER (NOT NHS NUMBER)

DATE OF BIRTH

HOW MANY CIGARETTES

HOW MANY YEARS

| | | |
|--------|---------|-----|
| SMOKER | CURRENT | Y/N |
| | EX | Y/N |
| | NEVER | Y/N |

Post bronchodilator spirometry requested (400mcg Salbutamol/ Ventolin via a spacer) Y/N

PATIENT SUITABLE FOR INHALED SALBUTAMOL Y/N

LIST OF MEDICATIONS PATIENT CURRENTLY TAKING

GP PRACTICE STAMP

GP/NURSE PRESCRIBER SIGNATURE & NAME

GP/ NURSE PRESCRIBER

Must delete as appropriate who has signed form
