



Forest Central Business Park
Building 1, Level 2, 49 Frenchs Forest Road
East
Frenchs Forest NSW 2086
Phone: 9975 4911 Fax: 9975 4622

Thank you for making an appointment at Peninsula Pulmonary Function Laboratory at Frenchs Forest.

Please read the below instructions carefully to prepare for your test.

What to bring?

- A current referral from your GP or specialist
- The completed Patient Registration Form and General Consent Form (enclosed)

How to prepare?

Stop any Inhalation medication/puffers as per below:

6 hours prior to testing

Bricanyl
Salbutamol (Ventolin, Asmol, Airomir)

12 hours prior to testing

Atrovent

24 hours prior to testing

• Breo	• Onbrez
• DuoResp	• Oxis
• Fluticason + Salmeterol	• Seretide
• Flutiform	• Serevent
• Fostair	• Symbicort

36 hours prior to testing


• Anoro	• Spiolto
• Braltus	• Spiriva
• Bretaris	• Ultibro
• Brimica	• Trelegy
• Incruse	
• Seebri	

You can continue any inhalation corticosteroids like Alvesco, Flixotide, Fluticasone, QVAR and Pulmicort.

Please note:

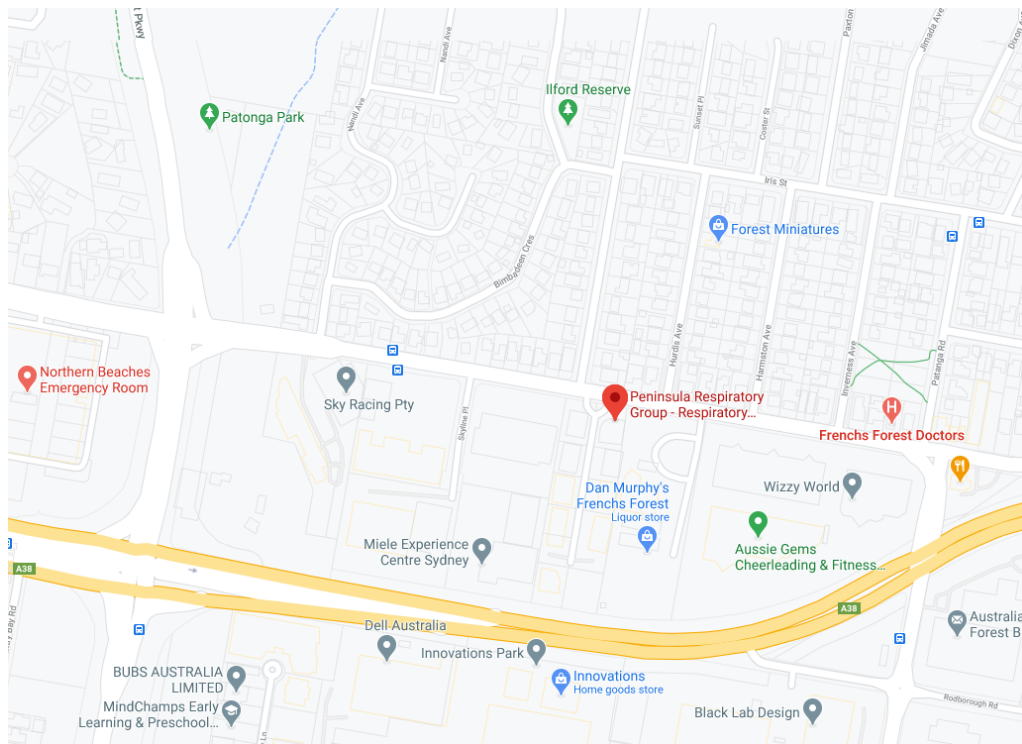
If you are too short of breath, please continue taking your puffers and inform the respiratory technician upon arrival in the respiratory lab.

Preparation on the day:

- No smoking/vaping for 8 hours prior to testing
- No alcohol, coffee, tea or caffeine containing drinks
- No vigorous exercise
-  A blood test is required with full lung function tests. This will be organised upon your arrival.
- Please arrive 15 minutes prior to your scheduled appointment.
- There is no extra cost to this blood test.

Where to go?

Our address is: Forest Central Business Park
Building 1, Level 2, 49 Frenchs Forest Road East
Frenchs Forest NSW 2086
Phone: 9975 4911 Fax: 9975 4622



Free parking is available in the carpark located underneath our clinic in Building 1. Access is via boom gate, please press 5 - *Peninsula Respiratory Group* on the keypad to enter. Alternatively, there is street parking available surrounding our clinic.

Bus route 166 stops in front of our clinic. Please check www.transportnsw.info for the latest information.

Costing?

The PFT laboratory is a private clinic and all fees are to be settled on the day of testing. Please contact us on 9975 4911 for any fee advice.

What to expect?

Lung function test

Throughout the test you will be seated. The respiratory technician is in the room with you and will instruct you to breathe through a mouthpiece with a nose peg on your nose. He/she will coach you through different breathing exercises. The results will assist the doctor to assess or review any lung problems. The test can take up to 45 minutes in total and includes lots of resting.

Skin prick test

During this test a set of allergens will be tested on the inside of your forearms. It is a painless procedure without any injections. The test will take 30 minutes.

Pulse oximetry test

You will be asked to wear a small portable device whilst sleeping in the comfort of your own bed. The next day when you return the device, the respiratory technician will review your oxygen levels and heart rate during your sleep.

For more information please visit us on www.peninsularespiratory.com.au

New Patient

Please fill out below paperwork and return to reception@peninsularespiratory.com.au or bring it with you on the day of the appointment.

PATIENT REGISTRATION FORM

SURNAME:

GIVEN NAMES:

Title: (please circle) Mr Mrs Miss M/s Dr

Date of Birth:

Address:

Home Phone Number:

Work Phone Number:

Mobile Phone Number:

REFERRING DOCTOR

Name:

Date of Referral:

GP (if different to referring doctor)

HEALTH COVER DETAILS

Name of Health Fund:

Health Fund Membership No:

Medicare Care Number: __ __ __ __ __ __ __ __ __ **Expiry Date:** **ID #:**

Pension No:

Dept Veterans' Affairs No:

If your DVA card is white, what are you specifically covered for by Veterans' Affairs?

Peninsula Respiratory Group routinely remind patients via telephone or SMS messaging of their up coming appointments within the Group. Do you consent to this contact? Yes or No

Patient Signature: _____

I understand that payment is required on the day of consultation or testing and all outstanding accounts owed to the Practice or the Respiratory Laboratory will be paid by me prior to leaving this office.

Signature of person responsible for account

Date

Patients **UNDER THE AGE OF 16 YEARS** please include parent's or guardian's details below:

SURNAME:

GIVEN NAMES:

Address:

Relationship to Patient:

Mobile Phone number:

Home Phone number:

Work Phone number:

NB: Parent/s / Guardian will be responsible for all accounts incurred

PENINSULA PULMONARY FUNCTION LABORATORY

Peninsula Respiratory Group acknowledges our obligations to you under the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988. Peninsula Respiratory Group Privacy Policy (Information Handling Procedures) is available on request.

12/10/21

Part A - Disclosure

Personal information we collect from you will be used primarily to assist us to provide you with optimal medical care. This also means that results from tests may be forwarded to health professionals and / or hospitals who are involved in your current or future care.

GENERAL CONSENT FOR THE DISCLOSURE OF PERSONAL / MEDICAL INFORMATION

Provided that Peninsula Respiratory Group and staff do their best to maintain the confidentiality of my medical record, I hereby consent to the disclosure of my personal / medical information for the purpose of my care and well-being (including by encrypted email). By doing so, I understand that certain information eg. investigation results, may be released to other health professionals and / or hospitals who currently, or in the future, have a bone fide interest in my treatment and care.

Print Name:

Signature:

Date:

Part B - Collection

At times it will be necessary to obtain information about you from a third party, eg medical facilities such as hospitals or other health professionals.

GENERAL CONSENT FOR THE COLLECTION OF PERSONAL / MEDICAL INFORMATION

Provided that Peninsula Respiratory Group and staff do their best to maintain the confidentiality of my medical record, I hereby consent to the collection of personal / medical information from a third party for the purpose of my care and well-being.

Print Name:

Signature:

Date: