SPIROMETRY CONSENT FORM

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Name: _____ DOB: _____
Phone Number: _____

For my breathing problem I want to do undergo a breathing test, Spirometry.

I understand Spirometry carries the risk of transmission of the COVID-19 virus which can cause COVID-19 disease. The risk of COVID-19 disease includes emergency room visits, hospitalization, ICU care, and even death.

- ***Asthma***
- ***Bronchitis***
- ***Chronic Cough***
- ***Dermatitis***
- ***Food Allergy***
- ***Recurrent Infections***
- ***Rhinitis***
- ***Urticaria***
- ***Immunodeficiency***
- ***Postnasal Drip***
- ***Rashes***
- ***Sinusitis***
- ***Wheezing***
- ***Drug Allergy***
- ***Insect Sting Allergy***

Herewith I consent for Spirometry.

I can refuse Spirometry.

_____
Patient's Signature
Typing my name is equivalent to signing this document electronically

_____
Witness Signature

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A few of many comments we receive from our patients:

"I thank you very much for taking care of me during my illness. You are indeed a healer for people with sickness due to allergies, asthma or any upper respiratory problems. You and your office staff can be commended for caring for your patients."

"Thank you for help during my time of need. I felt a real sense of concern and compassion from both yourself and your staff for my situation and treatment of hives.