COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

DIAGNOSTIC ACCREDITATION PROGRAM

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Appropriate Procedures List

PULMONARY FUNCTION

Physician name: _____ CPSID: _____

Independent diagnostic facility applying to: _____

Procedures must only be performed in an accredited diagnostic facility.

Please indicate only the procedures you wish to perform at the above-mentioned facility.

- ☐ Spirometry
- ☐ Flow volume loops
- ☐ Diffusing capacity
- ☐ Lung volumes
- ☐ Respiratory muscle testing
- ☐ Conductance/resistance
- ☐ Reactive airways (methacholine challenge testing)
- ☐ Exercise-induced asthma testing
- ☐ Cardiopulmonary exercise testing
- ☐ Pulse oximetry/overnight oximetry
- ☐ Exercise testing: duration test or six-minute walk test category

I hereby certify that the procedures selected in this application are within the scope of my current practice.

Physician signature: _____ Date: _____

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The personal information collected on this form is permitted under sections 26(c) and (e) of *FIPPA* for the purpose of managing your accreditation.

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