

## BETA-AGONIST REVERSIBILITY TESTING

BETA

Patient ID:	_1_			
Patient Initials:			_	
Visit Number:				
Visit Date:	/_		/_	
Technician ID:	nth	day		year

(Technician completed)

## Do NOT complete this form if the patient has not successfully completed the Lung Function Screening form (LUNGSCR).

01	1.	Spirometer serial number		
02	<b>PRE</b> 2.	-BRONCHODILATOR TESTING (PRE)  Time pre-bronchodilator testing started (based on 24-hour clock)		
	_	best effort reflects the run where the of FEV <sub>1</sub> and FVC are highest.		
03A	3.	Results of best effort	FVC	L
03B			FEV <sub>1</sub>	L
03C			PEFR _	L/S
03D			FEF <sub>25-75</sub>	L/S
04	4.	Was the pre-bronchodilator testing technically acceptable?		□ <sub>1</sub> Yes □ <sub>0</sub> No

## BETA-AGONIST REVERSIBILITY TESTING

Patient ID:	1
Visit Number:	

## POST-BRONCHODILATOR TESTING (POST)

05	5.	Time beta-agonist given (based on 24-hour clock)		
06	6.	Time post-bronchodilator testing started (based on 24-hour clock)		
		e best effort reflects the run where the n of FEV <sub>1</sub> and FVC are highest.		
07A	7.	Results of best effort after beta-agonist	FVC	L
07B			FEV <sub>1</sub>	L
07C			PEFR	L/S
07D			FEF <sub>25-75</sub>	L/S
08	8.	Was the post-bronchodilator testing technically acceptable?		□ <sub>1</sub> Yes □ <sub>0</sub> No