

MedStar Georgetown University Hospital Division of Pulmonary & Critical Care Medicine Pulmonary Function Lab

3800 Reservoir Road, NW • PHC Building, 5th Floor - 5030E Washington, DC 20007 202-444-8830 **scheduling** • 202-444-4982 **lab**

Suggested 7 days

nebulizer and

Methacholine Challenge Instruction

Patient Name:	Appointment:
Date and Time:	
asked to inhale a mist that contains different concentrations	t. This test is to determine the amount of airway irritability. You will be s of methacholine. The mist is produced by a device called a nebulizer ar after each period of inhalation, you will be asked to blow forcefully into a
1. Instructions for Medications:	
No exposure to the following in time period specified pri	or to challenge:
 Short-acting bronchodilators: Albuterol, Terbutaline 	8 hours
 Medium-acting bronchodilators: Anticollinergic agents Atrovent (ipratropium) 	24 hours
Long-acting bronchodilators: Salmetrol, FormoteralOral bronchodilators	48 hours
 Intermediate-acting Theophyline 	24 hours
- Long-acting theophylines - SioBid, StoPhylin, Unidur, Uniphylin, Theodur, T	48 hours eo-24
- Standard B2 agonist tablets	12 hours
Long-acting agonist tabletsAlbuterol-SR, Proventil-SP, Volmax	24 hours
 Cromolyn sodium - Intal 	8 hours
 Nedocromil - Tilade 	48 hours
 Hydroxazine, cetirizine - Anithistamine - Allegra, Clarinex, Claritin, Zyrtec 	3 days
 Leukotriene modifiers - Accolate, Singular 	24 hours

FOODS: No caffeine. This includes coffee or tea that is brewed, instant or iced. No colas or other soft drinks that contain caffeine. No chocolates, including candies, frosting, cookies, pies, cocoa or chocolate milk. No aspirin that contains caffeine, such as Anacin and Excedrin.

DAY OF STUDY

- 2. On the day of the study, eat only a light meal in the morning and no food three to four hours before the test.
- 3. If you have wheezing within 24 hours of the test or had a respiratory infection within the past six weeks, contact your physician and reschedule the test. Call 202-687-4982 to reschedule.
- 4. If you have or had in the past any of the following conditions, do not schedule this test and notify the physician ordering the test:
 - Heart attack or stroke within the last three months

• Steroids - inhaled or pills - at your physician's instructions

- Uncontrolled hypertension
- Aortic or cereberal aneurysem
- Use of Beta adrenergic medication; Lopressor, Atenalol, Propranolo, Inderal, Nardolol, Corzide, Inderide, Betopic, Timoptic
- Cardiovascular disease accompanied by bradycardia, vagotonia
- Peptic ulcer disease
- Thyroid disease
- Urinary tract obstruction
- Using a cholinesterase inhibitor for Myasthenia Gravis
- If you are pregnant and/or nursing
- 5. On the morning of the test complete and sign the patient questionnaire. Bring the completed, signed form and your ordering information from your physician.



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atient Name:		ID#:
.ge:	Height:	Weight:
1. Has a physician e	ver told you that you have asthma?	YES/NO
-	een hospitalized with asthma?	YES/NO
	piratory disease as a child?	YES/NO
4. Have you experie	enced asthma symptoms within the last two we	eks?
a. Wheezing		YES/NO
b. Chest tightr		YES/NO
c. Shortness o		YES/NO
	er, when did you last smoke:	
	espiratory infection within that last six weeks?	YES/NO
7. Have you had a h		
8. Do you have high		YES/NO
=	old that you have a aortic or cerebral aneurysm	
0. Are you pregnan	<u> </u>	YES/NO
	y of the following medications: Lopressor, Ater	
	e, Inderide, Betopic, Timoptic?	YES/NO
2. Do you have:		VECALO
a. Epilepsy	D.	YES/NO
b. Peptic ulcer		YES/NO
c. Thyroid dise		YES/NO
d. Urinary trac 3. Do you have Mya		YES/NO YES/NO
pace, use the back o	stomach problems and the total number of da of this page.	ays since your last dose for each medication. If you need mo Date and Time of Last Dose
Prug		Date and Time of Last Dose
atient Signature:		Date:
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