Lucile Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER
725 Welch Road Palo Alto, CA 94304

Medical Record Number

Patient Name

ORDERS • PEDIATRIC EXERCISE LABORATORY ORDER

Minimum of two forms of ID required
Addressograph or Label – Patient Name, Medical Record Number

Physician: Check all orders that pertain to the patient. Date, time & sign all orders.

Scheduling Phone (650) 721-2121 **Scheduling Fax Children's Heart Center** (650) 497-8422 **All Other Calls** (650) 498-2587

❑ **Cardiopulmonary Exercise Tolerance Test** ❑ **Exercise ECHO Exercise Tolerance Test**

❑ **Other:** _____ ❑ **Pediatric Nuclear Exercise Tolerance Test** ❑ **Research:** _____

SECTION A

ICD–9 Code(s) (Required) _____

Exam Requested: Cycle Ergometer: ❑ Seated ❑ Supine ❑ **Treadmill** **Test:** ❑ Priority ❑ Routine

Diagnosis: _____ **Reason for Test:** _____

Clinical History: _____

_____

Patient on Oxygen: ❑ Yes ❑ No **Other Concerns/Instructions:** _____

_____

SECTION B

Special Scheduling Information: ❑ Schedule directly with patient ❑ Schedule with Clinic Staff

Special Scheduling Concern or Instructions, i.e. Translation? ❑ No ❑ Yes: _____

Best time and way to reach patient/family: Name: _____ Phone #: _____ Time: _____

SECTION C

Required for Cardiopulmonary Exercise Tolerance Test. H&P suggested, REQUIRED for all Non-LPCH referrals

1. Allergies	❑ No	❑ Yes	7. Edema-Ankles/Face	❑ No	❑ Yes	13. Orthopedic Limitations	❑ No	❑ Yes
2. Airway Disease	❑ No	❑ Yes	8. High cholesterol	❑ No	❑ Yes	14. Reflux/Vomit	❑ No	❑ Yes
3. Chest Pain	❑ No	❑ Yes	9. Hx of Cancer	❑ No	❑ Yes	15. Sedentary	❑ No	❑ Yes
4. CNS Abnormal	❑ No	❑ Yes	10. Hx of Transplant	❑ No	❑ Yes	16. Shortness of Breath	❑ No	❑ Yes
5. Diabetes	❑ No	❑ Yes	11. Hypertension	❑ No	❑ Yes	17. Smoking (History of)	❑ No	❑ Yes
6. Dizzy/Syncope	❑ No	❑ Yes	12. Obesity	❑ No	❑ Yes	18. Unusual Tiredness	❑ No	❑ Yes

Primary Insurance Carrier: _____ **Secondary Insurance Carrier:** _____

Insurance ID#: _____ **Insurance ID#:** _____

Insurance Phone #: _____ **Insurance Phone #:** _____

Send a copy (back and front) of Insurance Card if possible for referrals from non-LPCH MDs.

Referring Location: _____ **OR** _____ **AND** _____
LPCH Office Phone Fax

DATE TIME	Provider Signature: Pager:	Noted by: Date/Time
Orders signed	**PRINT** Provider Name:	RN Signature Date/Time

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