Exercise Respiratory Center (ExRC) referral form

To send electronically, please log in to **epiccarelink.cookchildrens.org**.
To fax, please send completed form to **682-303-0719**.

Patient information

Date _____

Patient name _____ Date of birth _____ Gender _____

Address _____

Phone number _____ Sport(s) _____ Training _____ hours per week

Diagnostic testing performed previously (please fax results)

- ◯ Echocardiogram
- ◯ 12-lead ECG
- ◯ Cardiac stress test
- ◯ Lung function testing/spirometry and FeNO
- ◯ Bronchoscopy
- ◯ Laryngoscopy (at rest, during exercise or immediately after exercise?)
- ◯ Previous use of inhalers or asthma diagnosis
- ◯ Most recent Hgb/Hct ____/____ (date _____)

Patient's symptoms (please fax most recent clinic note)

- ◯ Shortness of breath (at rest, during exercise or after exercise?)
- ◯ Cough (at rest, during exercise or after exercise?)
- ◯ Wheezing (at rest, during exercise or after exercise?)
- ◯ Stridor (at rest, during exercise or after exercise?)
- ◯ Chest pain (at rest, during exercise or after exercise?)
- ◯ Dizziness/lightheadedness (at rest, during exercise or after exercise?)
- ◯ Syncope/fainting/near syncope (at rest, during exercise or after exercise?)
- ◯ Other _____

Specific questions/concerns or comments

Referral order: Please evaluate and treat this patient for exercise-induced respiratory symptoms.

Date _____

Referring physician signature _____ Referring physician name (printed) _____

Referring physician specialty _____ Phone _____ Fax _____

Fax referrals to 682-303-0719 and include a copy of the patient's insurance, any clinically relevant imaging, labs, history and demographics. If this is an urgent referral, please call our clinic directly at 682-303-4200.

cookchildrens.org/exrc