

NUCLEAR STRESS TEST QUESTIONNAIRE

Date of Your Test: _____

Your Name: _____

Date of Birth: _____ What is your weight? _____

What physician is referring you for this test? _____

What medications are you currently taking? Please list below.

Drug _____ Drug _____

Drug _____ Drug _____

Drug _____ Drug _____

Drug _____ Drug _____

Why were you asked to have this test performed: _____

Please tell us about your medical history: _____

Do you have any of the following risk factors:

Circle One

Family History of Heart Disease

Yes No

Diabetes

Yes No

Tobacco and/or Cigarette Use

Yes No

High blood pressure

Yes No

High cholesterol

Yes No

Females Only-----

1. Are you (Check appropriate box)

- Pre-menopausal, not surgically sterile. If so are you or do you think you may be pregnant? Yes No The date of your last menstrual cycle was: _____
- Pre-menopausal, surgically sterile.
- Peri-menopausal, If so are or do your think you may be pregnant?
 Yes No The date of your last menstrual cycle was: _____
- Post-menopausal

2. Are you currently breast-feeding? Yes No

Patient Signature: _____ Date: _____

University of Maryland Medical Center

CONSENT FOR SURGERY AND OTHER PROCEDURES: NUCLEAR STRESS TEST

1. I, _____, give permission to Dr. _____,
(Myself or name of patient)

his /her associates and such assistants under his/her supervision and control, as may be selected to perform the following procedure, surgery or treatment:

Exercise/Pharmacological Nuclear Stress Test: The stress test shows if your heart receives enough blood from its own arteries to work harder, safely. A nuclear stress test combines the treadmill portion with pictures(images) recorded on computerized gamma camera. Patients that are unable to walk on a treadmill or if your heart rate requirements of the walking study are not met, medication will be given to make the study more conclusive.
(Name or description of operation(s) or procedure(s))

2. Site/side of Operation: _____ N/A _____ Left Right N/A

3. I was told of the indications, benefits and probability of success of the surgery or procedure. These include: To assess if there is a blockage to the flow of blood to the heart muscle.

4. Risks

I was told that there is no sure way to know the result of the procedure, treatment or surgery. I was told of the potential risks or side effects listed below and of possible problems related to my recuperation. The major risks of the surgery or procedure may include, without limitation:

Dizziness, Flushing, Headache, Shortness of Breath, Chest pain, Heart Attack, Heart Arrhythmias, and Death.

5. Alternatives

I was told and understand the reasonable alternatives to the proposed surgery, procedure, treatment or service, the major risks of these alternatives, and the possible results if the recommended surgery, procedure, treatment or service is not performed.

Reasonable alternatives to the proposed treatment or procedure include:

Not to have the Stress test done.

The possible result of not performing the surgery or procedure may include:

The physician may not have enough information for complete and accurate diagnosis and treatment. Without proper treatment, symptoms may persist. Additional results of not doing the test include; Heart Attack, Heart Arrhythmia, and Possibly Death.

6. The following procedures may be done by a member of the treatment team.

The Stress Test will be conducted by cardiovascular technicians

7. MY SIGNATURE BELOW GIVES MY AGREEMENT:

- a. THAT I HAVE READ AND UNDERSTAND THIS CONSENT;
- b. THAT I HAVE RECEIVED ALL OF THE INFORMATION I WANTED ABOUT THE OPERATION OR PROCEDURE, ITS BENEFITS, RISKS, COMPLICATIONS AND ALTERNATIVE TREATMENT CHOICES; AND
- c. THAT I HAD A CHANCE TO DISCUSS AND HAVE MY QUESTIONS CLARIFIED BY THE HEALTHCARE PROVIDER TO MY SATISFACTION.

Signature of patient or surrogate: _____ Date: _____ Time: _____

Signature of witness: _____ Date: _____ Time: _____