



CARDIAC & VASCULAR CENTER
OF NORTH TEXAS

Information Consent for Nuclear Stress Testing

You have the right, as a patient to be informed about your condition and the recommended medical or diagnostic procedure to be used, so that you may make the decision whether or not to undergo the procedures after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure. I understand that the following medical and/or procedures are planned for me and I voluntarily consent and authorize these procedures. I understand that prior to the test I will have a clinical evaluation. This evaluation will include a brief medical history, physical examination consisting of, but not limited to, measurements of the heart rate, blood pressure and ECG.

TREADMILL EXERCISE TESTING: I understand that I will be required to walk on a treadmill. The amount of effort required will be gradually increased until such symptoms as fatigue, shortness of breath or discomfort may appear. I also understand that I will receive a small amount of radioactive tracer, which will be injected into my vein.

Patient Initial _____

INTRAVENOUS LEXISCAN INFUSION EXERCISE TEST: I understand that for the test I will be administered a medication called Lexiscan intravenously over a period of one to four minutes and a small amount of radioactive tracer. This medication will increase the blood flow to my heart as if I were to walk on the treadmill. I understand that I may also be required to walk slowly on the treadmill or do some type of light body movements in order to produce the best results.

Patient Initial _____

INTRAVENOUS DOBUTAMINE INFUSION EXERCISE TEST: I understand that for this test I will be administered a medication called Dobutamine intravenously over several minutes and a small amount of radioactive tracer. This medication will increase my heart rate gradually as if I were to walk on the treadmill.

Patient Initial _____

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the medical and/or diagnostic procedures planned for me. I realize that common to medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, abnormal blood pressures, fainting, difficulty breathing, disorders of the heart beat (too rapid, too slow) and, in very rare instances, heart attack and/or death. I understand that every effort will be made to minimize them and that emergency life saving techniques, including CPR, if necessary, will be employed and I authorize my physician and such associates, technical assistants and other healthcare providers to perform such life saving procedures, which are advisable in their professional judgment.

I understand that the information, which is obtained as a result of the test, will be treated as privileged and confidential and will not be released without my written consent.

I have read the foregoing and I understand it. The physician has explained to me the relevant treatment options and the risks of not having the procedure. Any questions, which may have occurred to me after reading this consent, have been answered to my satisfaction.

Print Name _____ Signature _____ Date _____

Witness Signature _____ Date _____



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Information Consent for Nuclear Stress Testing page 2

I hereby consent to voluntarily engage in an exercise test to determine the state of my heart and circulation. The information thus obtained will help to aid my physician in advising me as to the activities in which I may engage.

Before I undergo the test, I will have an interview with a physician. I will also be examined by a physician to determine if I have any conditions which would indicate that I should not engage in this test.

The test which I will undergo will be performed on a treadmill with the amount of effort increasing gradually. This increase in effort will continue until symptoms such as fatigue, shortness of breath or chest discomfort may appear, which would indicate to me to stop.

During the performance of the test, a physician or his/her trained observer will keep under the surveillance my pulse, blood pressure and electrocardiogram.

There exists the possibility of certain changes occurring during the test. They include abnormal blood pressure, fainting, disorders of the heartbeat, too rapid, too slow or ineffective and very rare instances of heart attack. Every effort will be made to minimize them by the preliminary examination and by observations during testing. Emergency equipment and trained personnel are available to deal with unusual situations which may arise.

The information which is obtained will be treated as privileged and confidential and will not be released or revealed to any person without my expressed written consent. The information obtained, however, may be used for a statistical or scientific purpose with my right to privacy retained.

I have read the foregoing and understand it and any questions which may have occurred to me have been answered to my satisfaction.

Print Name _____ **Signature** _____ **Date** _____

Witness Signature _____ **Date** _____

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