AMELIA HEART & VASCULAR CENTER

6136 Brandon Avenue
Springfield VA 22150
Ph: 703 866 3131
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2800 Shirlington Rd
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Azita Moalemi, MD, Naghmeh Tebyanian, MD, Arehzo Jahangiri, MD, Jody Ritter, DO, Zakeih Chaker, MD, Maryam Mohammadi, MD, Maryam Esfahani Zareh, PA, Jonathan Kiemel, PA, Kyla Nguyen, NP

Nuclear Stress Test/Lexiscan Instruction Packet Acknowledgement

_____ _____

Patient Name MR#

Initialing and signing of this document acknowledges the following:

_____ I have received a copy of the Instruction Packet.

_____ I understand I am to bring this packet back completed when I return for my appointment.

_____ I am **NOT** to have any caffeinated or decaffeinated products 24 hours or the morning or my test.

_____ I am **TO BE FASTING** (with the exception of water) for at least 4 hours before my test.

_____ I understand the test cannot be cancelled by using the automated system. I must **call** the office at 703-866-3131 **by 4:00PM the business day before** my test and speak to a staff member to cancel.

_____ I am aware that there is a $300 fee should the cancellation instructions above are not followed or if I cancel on the day of the appointment.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Staff Member as Witness Date

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Nuclear Stress Test / Lexiscan Instructions

****Complete the following two (2) pages and bring back on the day of your appointment****

Appointment Date:_____ Time:_____

1. **No caffeine for 24 hours before the test. No coffee or tea (including decaf), no chocolate, no Excedrin, no sodas, etc.**

2. **Do not take the following medications for 24 hours before test:**

Acebutolol	**Coreg**	**Sectra**
Atenolol	**Inderal/Inderal LA**	**Tenormin**
Bisoprolol	**Labetalol**	**Toprol XL**
Bystolic	**Lopressor**	**Trandate**
Cardizem	**Metoprolol**	**Zebeta**
Carvedilol	**Nandolol**	**Ziac**
Corgard	**Normodyne**	

Please take all your other medications unless told otherwise by your doctor.

3. **No food 4 hours before the test. Drink plenty of water so that you are well hydrated. If diabetic and your blood sugar is low, drink only fruit juice (ex. apple or orange juice).**

4. **Make sure you have showered the day of the test to remove excess skin oils. Do not use skin lotions or powders.**

5. **This test will last 3–4 hours.**

6. **Clothing and shoes should be comfortable and easy to exercise in. No dresses or one-piece jumpsuits. Do not wear high heels or slick-soled shoes.**

7. **For your comfort, you may want to bring a pullover sweatshirt or sweater without a zipper because some of the rooms are cold.**

8. **No guest or family may accompany you into the testing areas. They are welcome along but must wait in the lobby waiting room. If you would like a chaperone for your test, please let us know a day in advance.**

9. **The medication used for the camera images costs us $300 and expires by the afternoon. If you cannot make your appointment, you must call the office at 703-866-3131 and speak to a staff member by 4:00 pm the business day before the appointment (Friday by 4:00 pm for Monday appointments) in order to cancel the delivery of your dose. If not, you will be billed the cost of this dose ($300).**

AMELIA HEART & VASCULAR CENTER | PRIVIA MEDICAL GROUP

CONSENT FOR NUCLEAR STRESS TESTING

In order to determine an appropriate plan for medical management, 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 my physician advising me as to the activities in which I may engage. This test is designed to measure my fitness for work and/or sport, to determine the presence or absence of clinically significant heart disease, and/or to evaluate the effectiveness of my current therapy. As part of this assessment, I understand that I will be injected with radioactive isotope/tracer by IV.

Before I undergo this test, the procedure will be explained to me by the technologist, nurse, or doctor and any questions that I might have will be answered.

I understand that I will walk on a motor-driven treadmill. During the performance of physical activity, my electrocardiogram will be monitored and my blood pressure will be measured until I attain a predetermined end- point corresponding to moderate exercise, become distressed in any way, develop an abnormal response the physician considers significant, or whichever of the above occurs first.

Certain changes may occur during the test. They include abnormal blood pressure, fainting, disorders of heartbeat; too rapid, too slow, and in very rare instances, heart attack.

If I am unable to walk easily, a drug will be given to stimulate exercise. This may be Adenosine or Lexiscan depending on the individual condition. Side effects from these drugs are possible and may include shortness of breath, headache, and/or flushing.

Every effort will be made to minimize the possible side effects by the preliminary examination and by observations during testing. Emergency equipment and trained personnel are available to deal with unusual situations that may arise.

The information that is obtained will be treated as privileged and confidential and will not be released to any person without my expressed written consent.

_____ _____

Print Name **Date**

_____

Signature

_____

Witness

CARDIAC PATIENT HISTORY

Date_____

Name_____ Date of Birth _____ Height_____ Sex____

Have you had or do you have any of the following:

AIDS/HIV Yes_____ No_____

Hepatitis C Yes_____ No_____

Have you had any recent chest pain? Yes_____ No_____

Do you have chest pain with exertion? Yes_____ No_____

Do you have family members under 60 years old with heart problems? Yes_____ No_____

Do you have a Pacemaker or Defibrillator? (Circle which one you have). Yes_____ No_____

Have you had a prior attack? Yes_____ No_____

Have you had prior angioplasty/ stent/ bypass? (Circle which one you had). Yes_____ No_____

Do you smoke? Yes_____ No_____

Have you ever smoked? Yes_____ No_____

If yes, when did you quit? **(Put N/A if still smoking)** _____

Do you have high cholesterol? Yes_____ No_____

Do you have high blood pressure? Yes_____ No_____

Do you have congestive heart failure (CHF)? Yes_____ No_____

Do you have diabetes? Yes_____ No_____

Have you had a prior Nuclear Medicine study? Yes_____ No_____

Have you had caffeine in the last 24 hrs? Yes_____ No_____

(Coffee, tea, chocolate, Coke, decaffeinated drinks, etc.)

When did you last eat?_____

Current medications:_____

_____

When did you last take your medications? _____

Please list any allergies to drugs: _____

<u>*FEMALES ONLY – Please complete below and sign***</u>**

Are you pregnant? Yes_____ No_____ **Are you nursing? Yes_____ No_____**

Date of Your Last Menstrual Cycle _____ **Bra Size _____**

(If you are 55 or older, please skip this question.)

Signature _____ Date_____