CARDIOLOGY ASSOCIATES
MEDICAL GROUP, INC.

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INSTRUCCIONES PARA EL PACIENTE

LEXISCAN ESTUDIO DE PERFUSION MIOCARDIACA (MPS)

Nombre del Paciente: _____

Fecha: _____

Horario: _____

- Por favor venga a: 1701 Solar Dr., 150 (Solar Plaza)
  Oxnard, CA 93030
  (805) 278-4020

- NO TOME/COMA ningún producto que contenga CAFEINA o NICOTINA durante 24 HORAS antes de la prueba. (café, café descafeinado, té, chocolate, refrescos y algunos medicamentos como Excedrin y Anacin)

- Por favor, espere por lo menos TRES (3) HORAS para esta prueba. Esto no es una prueba difícil. Sin embargo, toma algún tiempo para complete todos los pasos.

- NO TOME/COMA nada CUATRO (4) HORAS antes de la prueba.

- Traiga algo pequeño para comer a su cita. Comida después de la inyección de material de imagen ayuda a la calidad de imagen.

- Use ropa suelta y cómoda.
  Las mujeres, por favor, use dos juegos de ropa separados arriba y al fondo, NO vestidos.
  Asegúrese de llevar calzado deportivo.

SI USTED NO PUEDE ASISTIR AL HORARIO DE SU CITA,
POR FAVOR LAME PARA CAMBIAR LA CITA AL MENOS DE 24 HORAS ANTES.

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CONSENTIMIENTO INFORMADO PARA LA PRUEBA DE ESFUERZO LEXISCAN

Estoy consintiendo a una prueba de esfuerzo mediante el uso de la administración inyección de Lexiscan.

Lexiscan es una sustancia química de origen natural en el cuerpo humano que se administra en una dosis más alta durante esta prueba. Su función es producir la dilatación de las arterias coronarias. La cámara detecta más tarde esta heterogeneidad del flujo de sangre al musculo del corazón.

Lexiscan es una inyección que se infunde durante diez (10) minutos. Algunos efectos comunes son, 28% el impulso de respirar profundamente, 26% dolor de cabeza, y 16% enrojecimiento de la piel. Rara vez las personas pueden sentir opresión en el pecho, dolor abdominal y nauseas. Graves efectos secundarios raros, menos de 3% ha sido documentado como ataques cardiacos no fatales, disminución de la presión arterial o el ritmo cardiaco anormal. Un médico presente en el sitio supervisara el estado del paciente durante la prueba. Equipo de emergencia también está disponible.

La información obtenida será tratada como secreta y confidencial y no será divulgada o revelada a ninguna persona sin mi consentimiento expreso por escrito. La información obtenida, sin embargo, se puede utilizar para un propósito estadísticos o científicos con la derecha de privacidad retenida.

1) He leído ese formulario? ☐ Si ☐ No
2) Entiende lo que ha leído? ☐ Si ☐ No
3) Tiene alguna pregunta? ☐ Si ☐ No

_____ (FIRMA DEL PACIENTE)

_____ (FECHA)

_____ (IMPRIMIR EL NOMBRE)

_____ (# DE CUENTA)

_____ (FIRMA DE TESTIGO)

_____ (FECHA)

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Fecha: _____ Nombre del Paciente: _____

Fecha de Nacimiento: _____ Medico Solicitante: _____

1. ¿Ha tenido alguna cafeína en las últimas 24 horas? ☐ NO ☐ SI,
   Si es así, por favor indique que y a qué hora _____
2. ¿Alguna vez has tenido un ataque al Corazón? ☐ NO ☐ SI, si es así, ¿cuando? _____
3. ¿Alguna vez has tenido una Angioplastia? ☐ NO ☐ SI, si es así, ¿cuando? _____
4. ¿Ha tenido una cirugía a Corazón Abierto? ☐ NO ☐ SI, si es así, ¿cuando? _____
5. ¿Fuma usted actualmente? ☐ NO ☐ SI
6. ¿Alguna Vez ha experimentado o ha sido diagnosticado con alguna de las siguientes opciones:
   ☐ Asma ☐ Diabetes ☐ Hipertensión ☐ Colesterol Alto
   ☐ Antecedentes familiares de enfermedades del Corazón, antes de la edad 55
7. ¿Ha estado teniendo dolor en el pecho/presión o síntomas relacionados?
   (mandíbula, cuello, garganta, brazos, espalda, etc...) ☐ NO ☐ SI, si es así, por favor indique
   - Ocurren los síntomas... ☐ en paz ☐ con esfuerzo ☐ ambos
   - Se alivian sus síntomas... ☐ con nitroglicerina ☐ en paz ☐ ambos ☐ ninguno
8. ¿Por qué su doctor ordeno este examen? _____

Lista de los medicamentos que ha tomado durante las <u>últimas 24 horas</u>:

Cuestionario adicional para los ***Pacientes Femeninos:***

1. Estas... (Marque la casilla correspondiente)
   ☐ Posmenopáusica
   ☐ Pre menopaúsicas, quirúrgicamente estéril, (eg, histerectomía, ligadura de trompas, etc.
   ☐ Pre menopaúsicas, no estériles quirúrgicamente,
   Si es así, esta o cree que pueda estar embarazada ☐ NO ☐ SI
2. Fecha de su último periodo menstrual fue: _____
3. ¿Alguna vez has tenido una mastectomía? ☐ NO ☐ SI, si es así, por favor indique
   ☐ Derecho ☐ Izquierda ☐ Implantes ☐ Prótesis
4. ¿Está actualmente amamantando? ☐ NO ☐ SI

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INFORMED CONSENT FOR LEXISCAN STRESS TEST

I am consenting to undergo a stress test by using a rapid injection of Lexiscan.

Lexiscan is a naturally occurring chemical in the human body which is administered at a higher dosage during this test. It works by producing dilation of the normal coronary arteries. The camera later detects blood flow to the heart muscle.

Lexiscan is a ten (10) second injection. Some common effects are, 28% feel an urge to breath deep, 26% feel a mild headache, and 16% feel flushing of the skin. Rarely people may feel chest tightness, abdominal pain and nausea. Rare serious side effects, <3% have been documented as nonfatal heart attacks, decrease in blood pressure or abnormal heart rhythms. A physician present at the site will monitor the person's suitability for the test and the actual test. Emergency equipment is also available.

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

1) Have you read this form? YES_____ NO_____

2) Do you understand what you have read? YES_____ NO_____

3) Do you have any questions? YES_____ NO_____

_____ (PATIENT SIGNATURE) _____ (DATE)

_____ (PRINT NAME) _____ (ACCT #)

_____ (WITNESS SIGNATURE) _____ (DATE)

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PATIENT INSTRUCTIONS

MYOCARDIAL PERFUSION STUDY (MPS)

Patient Name: _____

Date: _____

Time: _____

- Please come to: 1701 Solar Drive, Suite 150 (Solar Plaza)
  Oxnard, CA 93030
  (805) 278-4020

- DO NOT have any products containing CAFFEINE OR NICOTINE for 24 HOURS PRIOR to the test. (coffee, decaf, tea, chocolate, cola and some medications like Excedrin & Anacin)

- DO NOT take any Beta-Blockers or Calcium Channel Blockers 24 HOURS PRIOR to your appointment. SEE BACK FOR LIST OF THESE MEDS.

- Please allow at least THREE (3) HOURS for this test. This IS NOT a difficult test. However, it does take some time to complete all of the steps.

- Please take nothing by mouth FOUR (4) HOURS before the test.

- Bring a sandwich with some water/juice to your appointment. Eating after the injection of imaging material helps the image quality.

- Please wear loose and comfortable clothing.
  Shoes should be tennis or similar.
  Women, please separate top and bottom sets. NO dresses.

**PLEASE CALL TO RESCHEDULE AT LEAST 24 HOUR PRIOR,
IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT.**

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Nitro-Patch (NOT TO BE TAKEN 24 HOURS BEFORE THE TEST, UNLESS OTHERWISE INSTRUCTED BY YOUR PHYSICIAN)

Beta-Blockers (NOT TO BE TAKEN 24 HOURS BEFORE THE TEST, UNLESS OTHERWISE INSTRUCTED BY YOUR PHYSICIAN)

Acebutolol (Sectral)

Atenolol (Tenormin, Tenoretic)

Betaxolol (Kerlone)

Bisoprolol (Zebeta, Ziac)

Carteolol (Cartrol)

Carvedilol (Coreg)

Esmolol (Brevibloc)

Labetalol (Trandate, Normodyne)

Metoprolol (Toprol, Lopressor, Lopressor HCT)

Nadolol (Corgard)

Penbutolol (Levatol)

Pindolol (Visken)

Propranolol (Inderal, Inderide LA)

Sotalol (Betapace)

Timolol (Blocadren, Timolide)

Bystolic

Calcium Channel Blockers (NOT TO BE TAKEN 24 HOURS BEFORE THE TEST, UNLESS OTHERWISE INSTRUCTED BY YOUR PHYSICIAN)

Amlodipine (Norvasc)

Felodipine (Plendil)

Isradipine (DynaCirc)

Nicardipine (Cardene)

Nifedipine (Procardia XL, Adalat CC)

Nisoldipine (Sular)

Bepridil (Vascor)

Verapamil (Isoptin, Calan, Verelan)

Diltiazem (Cardizem CD, Cardizem SR, Dilacor XR, Tiazac)

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INFORMED CONSENT
(By Patient)

In order to evaluate the functional performance and capacity of my heart, lungs, and/or blood vessels, I hereby consent voluntarily to perform an exercise test.

I understand that prior to this test I will be questioned by a physician and have an electrocardiogram recorded to show whether or not testing should proceed. After this, I will walk and/or run on a treadmill, with speed and/or gradient increasing every 2 to 3 minutes until fatigue, breathlessness, chest pain and/or other symptoms are such that the effort must be discontinued. My electrocardiogram will be monitored while I am exercising.

I understand that the **RISKS** of testing include the possibility of changes in my heart rhythm, changes in blood pressure, fainting, and even the remote chance of heart attack – particularly if I take a hot shower shortly after strenuous exercise testing. I have been assured that the professional supervision will protect me as much as possible against injury by providing appropriate precautionary measures, and that in the unlikely event these precautions are insufficient in an emergency, hospital treatment will be available to me.

I understand that the **BENEFITS** of testing include quantitative assessment of my working capacity, and appraisal of disorders or diseases that impair capacity, and that this knowledge facilitates appropriate treatment and accurate prognosis of further cardiac events.

I have been assured that I have the right to stop this exercise test at any time and that the confidential information about me will not be given to non-medical persons (such as employers and insurance agents) without my consent.

1) Have you read this form? YES_____ NO_____

2) Do you understand what you have read? YES_____ NO_____

3) Do you have any questions? YES_____ NO_____

_____ _____
(PATIENT SIGNATURE) **(DATE)**

_____ _____
(PRINT NAME) (ACCT #)

_____ _____
(WITNESS SIGNATURE) (DATE)

100 N. Brent Street, Suite 301
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NUCLEAR CARDIOLOGY QUESTIONAIRE

Date: _____ Patient's Name: _____

D.O.B: _____ Ordering Physician: _____

1. **Have you had any CAFFEINE within the past 24 hours?** ☐ NO ☐ YES, **If so, please indicate what and what time**_____
2. Have you ever had a heart attack? ☐ NO ☐ YES, if so, when? _____
3. Have you ever had an Angioplasty? ☐ NO ☐ YES, if so, when? _____
4. Have you had Open-Heart surgery? ☐ NO ☐ YES, if so, when? _____
5. Do you currently Smoke ☐ NO ☐ YES
6. Have you ever experienced or been diagnosed with any of the following:
   ☐ Asthma ☐ Diabetes ☐ Hypertension ☐ High Cholesterol
   ☐ Family history of Heart Disease, BEFORE the age of 55
7. Have you been experiencing any chest pain/pressure or related symptoms? (jaw, neck, throat, arm, back, etc…) ☐ NO ☐ YES, if so, please indicate…

- Do your symptoms occur… ☐ at rest ☐ with exertion ☐ both
- Are your symptoms relieved… ☐ with nitroglycerin ☐ with rest ☐ both ☐ neither

8. Why did your Doctor order this test? _____

List any medication you have taken <u>within the last 24 hours</u>:

Medications:				
Dose (mg):				
Taken:				

Additional questionnaire for ***Female Patients ONLY:***

1. Are you...(check the appropriate box)
   ☐ Post-menopausal
   ☐ Premenopausal, surgically sterile (e.g. hysterectomy, tubal ligation, etc.)
   ☐ Premenopausal, not surgically sterile,
   if so, are you or do you think you may be pregnant ☐ NO ☐ YES
2. The date of your last menstrual period was: _____
3. Have you ever had a mastectomy? ☐ NO ☐ YES, if so, please indicate…
   ☐ Right ☐ Left ☐ Implant ☐ Prosthesis
4. Are you currently breastfeeding? ☐ NO ☐ YES

Patient Signature_____

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