DELAWARE
CARDIOVASCULAR
ASSOCIATES

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EXERCISE STRESS TEST CONSENT FORM

YOUR DOCTOR HAS ASKED YOU TO PERFORM AN EXERCISE TEST AT DELAWARE CARDIOVASCULAR ASSOCIATES TO EVALUATE THE FUNCTIONAL STATUS OF YOUR HEART, TO DETECT THE POSSIBLE PRESENCE OF HEART DISEASE, AND TO HELP DETECT THE FUTURE OCCURRENCE OF SUCH DISEASE. THIS WILL FACILITATE YOUR TREATMENT AND MORE ACCURATELY DETERMINE YOUR PROGNOSIS.

THE EXERCISE WILL BE PERFORMED BY WALKING ON A TREADMILL WITH THE SPEED AND GRADE INCREASING EVERY FEW MINUTES UNTIL YOU EXPERIENCE FATIGUE, BREATHLESSNESS, CHEST PAIN, AND/OR OTHER SYMPTOMS THAT SUGGEST THAT YOU SHOULD STOP. IF AT ANY TIME DURING THE TEST YOU FEEL YOU WOULD LIKE TO STOP, THE TEST WILL BE TERMINATED. DURING THE TEST, YOUR BLOOD PRESSURE, HEART RHYTHM AND ELECTROCARDIOGRAM WILL BE MONITORED BY A PHYSICIAN.

THE RISKS OF THE TEST INCLUDE ABNORMALITIES OF HEART RHYTHM, EXCESSIVELY HIGH OR EXCESSIVELY LOW HEART RATE, IRREGULAR RHYTHM, ABNORMAL BLOOD PRESSURE RESPONSE, AND, THOUGH RARELY REPORTED (2-3 PER 10,000) HEART ATTACK OR DEATH. EQUIPMENT AND TRAINED PERSONNEL ARE AVAILABLE TO DEAL WITH UNUSUAL SITUATIONS SHOULD THEY ARISE. IF YOU SHOWER WITHIN ONE HOUR OF THE TEST, YOU SHOULD DO SO WITH LUKEWARM WATER SINCE SHOWERING WITH HOT WATER FOLLOWING STRENUOUS EXERTION COULD CAUSE YOU TO FAINT.

AN ELECTROCARDIOGRAM WILL BE TAKEN AND INTERPRETED PRIOR TO THE TEST. YOU WILL BE QUESTIONED AND YOUR HEART EXAMINED BY A PHYSICIAN TO EXCLUDE ANY CONTRAINDICATIONS TO PERFORMING THE TEST.

I UNDERSTAND THAT RECORDS OF THE TEST WILL BE KEPT AT DELAWARE CARDIOVASCULAR ASSOCIATES WITH A COPY FORWARDED TO YOUR REFERRING PHYSICIAN, AND THAT I MAY WITHHOLD RESULTS FROM NON-MEDICAL PERSONS (EMPLOYERS, INSURANCE AGENTS, ETC.). I PERMIT REGISTRATION OF MY NAME FOR POSSIBLE FOLLOW UP PURPOSES.

HAVING READ THE ABOVE, AND UNDERSTANDING THE INDICATIONS FOR THE PROCEDURE, THE METHOD IN WHICH IT IS TO BE PERFORMED, AND THE POSSIBLE COMPLICATIONS, I HEREBY ACCEPT THE RISKS AS STATED AND AGREE TO PERFORM THE TREADMILL EXERCISE AS REQUESTED BY MY PHYSICIAN.

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PATIENT SIGNATURE DATE

THE ABOVE PATIENT HAS BEEN EXAMINED BY ME TODAY AND I HAVE FOUND NO CONTRAINDICATIONS TO EXERCISE TESTING. HE/SHE HAS BEEN GIVEN THE OPPORTUNITY TO HAVE HIS/HER QUESTIONS ABOUT THE TEST ANSWERED.

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WITNESS SIGNATURE PHYSICIAN SIGNATURE