West Georgia Cardiology, LLC.
Patient Instructions
Treadmill Stress Test

1. Please arrive at West Georgia Cardiology at your scheduled test time.

2. Your test will take approx. 1 1/2 hours.

3. Nothing to eat or drink 3 hours prior to your test.

4. Unless otherwise instructed, please hold all blood pressure medications on the day of the test.

5. If you take any Beta-Blockers, Calcium Channel Blockers, and Nitrates please hold the day before and the morning of the test, unless otherwise instructed.
   a. Name of Medication to hold:______________________________

   ____

6. Bring all medications with you to your appointment.

7. Wear comfortable clothes and shoes that tie.

8. I __________________________________ am signing this form acknowledging that I was given the above instructions to follow to prepare for this test.
   ** Nurse make copy for office file. ***

West Georgia Cardiology, LLC
129 Bankhead Highway, Carrollton, GA 30117
770/838-8440 * Fax: 770/838-8443
Dr. Charlie Rouse
Adrianne West, NP

Treadmill Stress Test Consent Form

Date: ________________ Patient: ____________________________ MR#____________________

I, for myself, or for the patient named above, do hereby authorize Dr. _______________________ and/or his assistants to administer and conduct an exercise stress test. This test is designed to determine the presence or absence of clinically significant heart disease; to evaluate the effectiveness of my current therapy; and/or to asses my safe exercise capacity.

I understand that I will walk on a treadmill at a specific speed and grade and at three-minute intervals the speed and elevation will increase. While walking on the treadmill, my electrocardiogram and blood pressure will be monitored by a nurse practioner or a physician assistant. Exercise will be progressively increased until I attain a predetermined end point corresponding to moderate exercise stress, or become distressed in any way or develop any abnormal response the mid-level considers significant, whichever of the above occurs first.

Every effort will be made to conduct the test in such a way as to minimize discomfort and risk. However, I understand that just as with other types of diagnostic tests there are potential risks associated with an exercise test. These include episodes of lightheadedness, fainting, chest discomfort, leg cramps and very rarely heart attacks or sudden death. I further understand that the laboratory is properly equipped for such situations and that its professional personnel are trained to administer any emergency care necessary. I voluntarily accept the risks associated with the above procedures.

____ ______________________

Signature of patient or legal representative Date

____ ______________________

Signature of witness Date