West Georgia Cardiology

Thallium Instruction Sheet

1. Your test will take approximately 3 hours to complete.

2. Nothing to eat or drink after 9 p.m. the night before test.

3. No caffeinated or decaffeinated coffee, tea or soda for ***48hrs***. before the test.

4. ***Is the patient of child bearing age (12-62), if so check the following:***
   a. Hysterectomy- Y or N b. Menopause Y or N

   If no to the above questions then Beta HCG should be performed.

5. If you are a diabetic and on insulin, only take a ½ dose the night before the test and none the day of the test. If you are on an insulin pump, decrease the basal rate by 1/ 2 at 900 pm the night before the test.

6. You can bring a light snack to eat after stress portion of test. (ex. crackers, juice, fruit)

7. Unless otherwise instructed, please hold all morning medications on the day of the test.

8. If you take any Beta-Blockers, Calcium Channel Blockers, Nitrates or Ranexa please hold for 48 hrs. before the test, unless otherwise instructed.
   a. Name of Medication to hold:_____
   _____

9. Bring all medications with you to your appointment.

10. Wear comfortable clothes and shoes that tie. Bring jacket or coat.

11. ***It is extremely important that you follow the instructions given thoroughly and notify our office 24 hours prior to your scheduled appointment time if cancellation is needed. Failure to follow instructions or failure to cancel within 24 hrs will result in a $180.00 cancellation fee. Failure to follow instructions appropriately can affect the quality of images and diagnostic outcome of your test.***

12. ***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.****

Nuclear Cardiology
Accredited Nuclear Cardiology Laboratory

West Georgia Cardiology
129 Bankhead Highway, Carrollton, GA 30117
770/838-8440 * Fax: 770/838-8443

Nuclear 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 nuclear 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. Just before the test is terminated and injection of radioisotope (Tc-99m Myoview) is given through an intravenous site and I am required to walk an additional minute on the treadmill to allow significant circulation and accumulation of the isotope in my heart.

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. There is no risk or side effects associated with the radioisotope injection. 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.

****A $180.00 fee will be charged if I do not call to cancel 24 hours prior to my appointment or do not show. This fee will also be charged if I fail to follow the instructions thoroughly given which will result in cancellation.**

_____ _____
Signature of patient or legal representative Date

_____ _____
Signature of witness Date