295 Stoner Avenue
Suite 103
Westminster, MD 21157
410-876-0086

UNIVERSITY OF MARYLAND

CARDIOLOGY PHYSICIANS

Dear Patient:

You are scheduled for a Exercise Treadmill Test on _____

at_____. Please read and follow the instructions given below.

1. Please complete the questionnaire on the back and bring it with you on the day of your appointment.

2. Bring a current list of medications and all insurance cards with you.

3. Do not smoke or consume alcoholic beverages. Do not consume caffeinated or decaffeinated products on the day of the test.

4. Wear comfortable clothes and walking shoes (NO dresses).

5. Take all medications as instructed, do not withhold any medications unless directed.

6. Please call us at 410-876-0086, should you have any questions.

If you are unable to keep this appointment, please notify our office immediately.

EXERCISE TREADMILL TEST QUESTIONNAIRE

Date of Your Test:_____

Your Name:_____

Date of Birth:_____

What is your weight?_____

What physician is referring you for this test?_____

What medications are you currently taking?

Drug_____ Drug_____

Drug_____ Drug_____

Drug_____ Drug_____

Drug_____ Drug_____

Why were you asked to have this test performed:_____

_____

Please tell us about your medical history:_____

_____

Do you have any of the following risk factors:	Circle One	
Family History of Heart Disease	Yes	No
Diabetes	Yes	No
Tobacco and/or Cigarette Use	Yes	No
High blood pressure	Yes	No
High cholesterol	Yes	No

University of Maryland Medical Center
CONSENT FOR SURGERY AND OTHER
PROCEDURES: EXERCISE STRESS TEST

1. I, _____, give permission to
Dr._____,
(Myself or name of patient)
his /her associates and such assistants under his/her supervision and control, as may be selected to perform the following procedure, surgery or treatment:

□ Exercise Stress Test: The stress test shows if your heart receives enough blood from its own arteries to work harder, safely.
(Name or description of operation(s) or procedure(s))

2. Site/side of Operation: _____N/A_____ □ Left □ Right X N/A

3. I was told of the indications, benefits and probability of success of the surgery or procedure. These include:
To assess if there is a blockage to the flow of blood to the heart muscle.

4. **Risks**
I was told that there is no sure way to know the result of the procedure, treatment or surgery. I was told of the potential risks or side effects listed below and of possible problems related to my recuperation. The major risks of the surgery or procedure may include, without limitation:
Dizziness, Flushing, Headache, Shortness of Breath, Chest pain, Heart Attack, Heart Arrhythmias, and Death.

5. **Alternatives**
I was told and understand the reasonable alternatives to the proposed surgery, procedure, treatment or service, the major risks of these alternatives, and the possible results if the recommended surgery, procedure, treatment or service is not performed.

Reasonable alternatives to the proposed treatment or procedure include:
Not to have the Stress test done.

The possible result of not performing the surgery or procedure may include:
The physician may not have enough information for complete and accurate diagnosis and treatment. Without proper treatment, symptoms may persist. Additional results of not doing the test include; Heart Attack, Heart Arrhythmia, and Possibly Death.

6. The following procedures may be done by a member of the treatment team.
The Stress Test will be conducted by cardiovascular technicians

7. MY SIGNATURE BELOW GIVES MY AGREEMENT:
a. THAT I HAVE READ AND UNDERSTAND THIS CONSENT;
b. THAT I HAVE RECEIVED ALL OF THE INFORMATION I WANTED ABOUT THE OPERATION OR PROCEDURE, ITS BENEFITS, RISKS, COMPLICATIONS AND ALTERNATIVE TREATMENT CHOICES; AND
c. THAT I HAD A CHANCE TO DISCUSS AND HAVE MY QUESTIONS CLARIFIED BY THE HEALTHCARE PROVIDER TO MY SATISFACTION.

Signature of patient or surrogate: _____ Date: _____ Time:_____

Signature of witness: _____ Date: _____ Time: _____