



Myoview (cardiolite) Treadmill Stress Test Instructions

Patient Name: _____

Appointment Date: _____ **Time:** _____

_____ 700 Shadow Ln # 240
Las Vegas, NV 89106
702-384-0022

_____ 1815 E. Lake Mead Blvd #110
N. Las Vegas, NV 89030
702-642-9010

_____ 3196 S. Maryland Pkwy #207
Las Vegas, NV 89109
702-732-0022

_____ 5380 S. Rainbow Blvd # 228
Las Vegas, NV 89118
702-260-0022

_____ 10001 S. Eastern Ave # 403
Henderson, NV 89052
702-754-0622

INSTRUCTIONS:

NO CAFFEINE/ DE-CAFFINATED/ NICOTINE 24hrs prior to the test, Includes, tea, soda, chocolate, energy drinks, Anacin, Excedrin, No-DOS

Drink plenty of WATER **THE DAY PRIOR AND DAY OF.**

NOTHING TO EAT OR DRINK AFTER MIDNIGHT, WATER IS OK

Take medication as prescribed **except any Beta Blockers for Hypertension or Arrhythmias** (please see list in second page)

Wear comfortable clothing, **NO** Dresses, one piece outfits

DIABETIC PATIENTS: PLEASE DON'T TAKE INSULIN OR MEDICATIONS in the morning of the test, bring them with you to take on your lunch break.

Any respiratory medications, **THEOPHYLINE, THEO-DUR, AMINOPHYLINE, DIPYRIDAMOLE** hold if possible 48 hours before test. Bring inhalers with you.

The test will take 2-3 hours in the am and 1-2 in the afternoon.

Bring a lunch.

If you need to cancel, reschedule, have any questions, please contact us. If you DO NOT CANCEL OR RESCHEDULE WITHIN 24HRS OF THE TEST YOU WILL BE CHARGED \$150.00. If you are later than 30 minutes you will be charged \$150.00.

What to expect:

During the first part of the, the patient is given an IV, then a dose of radioisotope is injected. After approximately 15 to 20 minutes, photos of the heart are taken.

During the second part of the test, the patient is asked to walk on a treadmill with the IV in place while being monitored for EKG and/ or blood pressure changes. The patient is again injected with one more dose of the radioisotope. The patient is then monitored for a recovery period of approximately 5 to 10 minutes.

The technician will indicate when the patient can leave for a lunch break and what time to return. When the patient comes back, the patient is again asked to lie on a table and photos are taken of the heart. This will take about 10-15 minutes.

If you need to cancel, reschedule, have any questions, please contact us. If you DO NOT CANCEL OR RESCHEDULE WITHIN 24HRS OF THE TEST YOU WILL BE CHARGED \$150.00. If you are later than 30 minutes you will be charged \$150.00.

IF YOU ARE TAKING ANY OF THE FOLLOWING MEDICATIONS PLEASE **DO NOT** TAKE THEM FOR 24 HOURS PRIOR TO YOUR **EXERCISE STRESS TEST OR DOBUTAMINE STRESS TEST:**

BRAND NAME

BETAPACE
BLOCADREN
CARDIZEM LA
CARTROL
COREG
CORGARD
CORZIDE
INDERAL
INDERIDE
LEVATOL
NORMODYNE
SECTRAL
LOPRESSOR
TENORMIN
TENORETIC
TIMOLIDE
TOPROL
TRANDATE
VERAPAMIL
VISKEN
ZEBETA
ZIAC

GENERIC NAME

SOTALOL
TIMOLOL
DILTIAZEM
CARTEOLOL
CARVEDILOL
NADOLOL
BENDROFULMETHIAZIDE
PROPANOLOL
METOPROLOL
PENBUTOLOL
PENBUTOLOL
ACEBUTOLOL
ATENOLOL
LABETALOL
PINDOLOL
BISOPROLOL
DILTIAZEM
BYSTOLIC

HYDROCHLOROTHIAZIDE
BISOPROLOL
BISOPROLOL + HCTZ



CONSENT FOR CARDIAC STRESS TEST

1. In order to determine and appropriate plan of medical management. I hereby consent to voluntarily engage in a cardiac stress to determine the state of my heart and circulation. The information thus abstained will help my physician in advising me as to the activities which I may engage. The test is designed to measure my fitness for work and or/ sport determine the presence or absence of clinically significant heart disease and/ or to evaluate the effectiveness of my current history.
2. Before I undergo the test, I will have an interview with a physician. I will also be examined by a physician to determine if I have any condition which would indicate that I should not engage in this test.
3. I understand that I will be participating in an exercise or pharmacologically induced stress test. During the performance of the cardiac stress test my electrocardiogram will be monitored and my blood pressure will be measured until I attain a predetermined end point corresponding to moderate exercise stress, or become distressed in any way or develop any abnormal response that the physician considers significant whichever of the above occurs first.
4. There exists the possibility of certain changes during the tests, they include abnormal blood pressure, fainting, disorders of the heartbeat (too rapid, slow or ineffective, and a very rare instance of heart attack. Every effort will be made to minimize those occurrences by the preliminary and observations during testing. Emergency equipment and trained personnel are available to deal with unusual situations that may arise.
5. The information that is obtained will be treated as privileges and confidential and will not be released or revealed to any person without my expressed consent. The information obtained however, may be used for statistical or scientific purpose with my right of privacy retained.
6. I have discussed this procedure with my physician, _____ M.D.

PATIENT NAME: _____ Date of Birth: _____

Height: _____ Weight: _____ ARE YOU PREGNANT? NO YES

ARE YOU BREASTFEEDING? NO YES

DO YOU SMOKE? NO YES ARE YOU DIABETIC? NO YES

MEDICATIONS

1. _____ 2. _____

3. _____ 4. _____

Date: _____

Signed: _____

Witness: _____