



PLACE LABEL HERE.  
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

### CONSENT FOR EXERCISE STRESS TEST

#### A. CONSENT FOR PROCEDURE

1. I authorize \_\_\_\_\_ to perform the following procedure(s):

#### EXERCISE STRESS TEST

I understand that I may need other urgent procedures that were unanticipated. I consent to the performance of any additional procedures determined during my original procedure to be in my interests and where delay might cause additional harm.

I understand that other qualified practitioners may be chosen to do or help with procedures. I UNDERSTAND THAT PHYSICIANS IN TRAINING, INCLUDING RESIDENTS (DOCTORS WHO HAVE FINISHED MEDICAL SCHOOL AND ARE GETTING MORE TRAINING), CARDIOLOGY FELLOWS, AND REGISTERED NURSES MAY PERFORM PORTIONS OF THE PROCEDURES DESCRIBED ABOVE UNDER THE PARTICIPATORY SUPERVISION OF MY ATTENDING PHYSICIAN. All qualified practitioners will only perform tasks that are within their scopes of practice and for which they have been granted clinical privileges.

2. I understand the purpose of this test to be:

**RULE-OUT CORONARY ARTERY DISEASE/RULE-OUT ISCHEMIA.**

**OTHER:** \_\_\_\_\_

3. I have been told about and understand the risks and benefits of the procedure(s) listed above. These risks, which can be serious, include: **MUSCULOSKELETAL TRAUMA, FATIGUE, DIZZINESS OR FAINTING, CHEST DISCOMFORT OR HEART POUNDING, SHORTNESS OF BREATH, SLOW OR RAPID HEART RHYTHMS, ABNORMAL HEART RHYTHMS, LOW OR HIGH BLOOD PRESSURE, CONGESTIVE HEART FAILURE, STROKE, HEART ATTACK, SHOCK, CARDIAC ARREST AND DEATH.**

4. I understand the alternatives to the proposed procedure and the related risks to be: **NO TEST.**

The related risks of proposed alternative treatment are failure or delay in the diagnosis of coronary artery disease.

5. I understand that for some kinds of medical equipment used during procedures, a representative from the equipment manufacturer may be present, providing consultation or performing checks on the equipment.

6. I understand that photographs and/or video or electronic recordings may occur during my procedure and may be used for internal performance improvement or educational purposes.

(CONTINUED ON NEXT PAGE)



0100000

PLACE LABEL HERE.

---

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

**B. PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:**

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form and I agree to receive the care, treatment or services listed on this consent. I have had a chance to ask questions and all of my questions have been answered.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	PRINTED NAME	DATE	TIME	

IF SIGNED BY PERSON OTHER THAN THE ADULT PATIENT, CHECK RELATIONSHIP TO PATIENT:

<input type="checkbox"/> 1. Agent Named in Advance Directive	<input type="checkbox"/> 4. Adult Child	<input type="checkbox"/> 7. Other Blood Relative
<input type="checkbox"/> 2. Guardian	<input type="checkbox"/> 5. Parent	<input type="checkbox"/> 8. Other* _____
<input type="checkbox"/> 3. Husband/Wife	<input type="checkbox"/> 6. Adult Brother/Sister	

FOR MINOR PATIENTS:

<input type="checkbox"/> 1. Parents	<input type="checkbox"/> 2. Guardian or Legal Custodian	<input type="checkbox"/> 3. Authorized person for child in out-of-home placement
-------------------------------------	---	--

\* Requires review and appointment by Ethics Consult Service. See Medical Center Policy 024, Informed Consent.

**C. PHYSICIAN STATEMENT/SIGNATURE & WITNESS SIGNATURE:**

I have explained the procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative. The patient and/or their representative has communicated to me that they understand the contents of this form.

SIGNATURE OF PHYSICIAN OR DESIGNEE OBTAINING CONSENT	PRINTED NAME	PIC #	DATE	TIME	

SIGNATURE OF WITNESS (OPTIONAL) REQUIRED FOR TELEPHONE CONSENTS	PRINTED NAME	DATE	TIME		

**D. INTERPRETER ATTESTATION:**

Interpretation has been provided by:

SIGNATURE OF INTERPRETER/CYRACOM ID #	PRINTED NAME	DATE	TIME		