

STRESS TEST WORKSHEET

Pt. Name: _____
 Address: _____
 City/State/Zip: _____
 Phone – (H) _____ (W) _____
 DOB: ____/____/____
 Height: _____ Weight: _____
 DX/Indication: _____

Today's Date: _____
 Pt. Account #: _____
 Male Female
 PCP Name: _____
 SS# _____
 Insurance: _____
 ID#: _____
 Ref/Auth#: _____

****Attach copy of current ECG.****

Documented Myocardial Infarction? Yes No
 Is the patient a smoker? Yes No
 History of COPD? Yes No
 Currently on beta-blockers? Yes No

Can patient stop use of beta-blockers for 24 hours before test? Yes No

Does the Pt. have any of these contraindications to stress testing:

- Yes No Acute Myocardial Infarction (within 2 days)
- Yes No Unstable angina not previously stabilized by medical therapy
- Yes No Uncontrolled cardiac arrhythmias
- Yes No Symptomatic severe aortic stenosis
- Yes No Uncontrolled symptomatic heart failure
- Yes No Acute pulmonary embolus or pulmonary infarction
- Yes No Acute myocarditis or pericarditis
- Yes No Acute aortic dissection

IF YES TO CONTRAINDICATIONS TO STRESS TESTING, CONSULT **CARDIOVASCULAR CONSULTANTS OF MAINE 885-9904 *Physician Line Only* – not for routine scheduling**

IF NO → Can the Pt. walk more than 100 ft. without stopping? **Yes** **No**

→ **IF NO** → Pharmacologic Imaging Stress Test

→ **IF YES** → Does the Pt.'s ECG have:

- Yes No Left bundle branch block
- Yes No Ventricular paced rhythm
- Yes No Left ventricular hypertrophy w/ re-polarization abnormalities
- Yes No Digoxin treatment
- Yes No Baseline ST-T abnormalities

IF YES to ECG questions → Imaging Stress Test

IF NO to ECG questions → Exercise Stress Test (Non Imaging)

If a **prior stress test** has been done, when _____ and where _____

Need appointment within: 2-3 days 1 Week 2 Weeks **URGENT** (PCP to call cardiologist if urgent).

CARDIOVASCULAR CONSULTANTS OF MAINE Fax 396-5618 Phone 885-9905

Preferred CCM cardiologist if applicable: _____

Non-urgent testing available at Park Avenue (Dr. Bill Ervin) Fax 774-8477

Return form by fax to (Your Fax#) _____ (Your Name) _____

Test Ordered: <input type="checkbox"/> Non Imaging Stress Test <input type="checkbox"/> Stress Echo <input type="checkbox"/> Cardiolite <input type="checkbox"/> Exercise; or Comments: _____ <input type="checkbox"/> Adenosine <p style="text-align: center;"><i>To be completed by cardiologist or PCP performing test</i></p>
--

Date of Appointment _____ Appt. With _____ Pt. Aware? Yes No
 Revised 9/03 Verbally By Mail