

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.****

- Yes No Documented Myocardial Infarction?
- Yes No Is the patient a smoker?
- Yes No History of COPD?
- Yes No Currently on beta-blockers, calcium blocker (Diltiazem/Verapamil)?
- Yes No Can patient stop use of beta-blockers/Calcium blockers for 24 hours before test?
- 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 **CARDIOLOGIST 523-8500**

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

IF NO → Pharmacologic Imaging Stress Test to be ordered

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 – may generate false positive ECG changes
- Yes No Baseline ST-T abnormalities

IF YES to ECG questions → Imaging Stress Test to be ordered

IF NO to ECG questions → Non Imaging Exercise Stress Test to be ordered

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).

INTERMED CARDIOLOGY Fax 879-6048 Phone 523-8500

If InterMed Cardiology not available, Contact Cardiovascular Consultants of Maine Fax 396-5618 Phone 885-9905

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

Test Ordered: Non Imaging MLET Exercise MIBI Adenosine MIBI Dobutamine MIBI Stress Echo

To be completed by cardiologist

Other Instructions:

Date & Time of Appointment _____ Appt. With _____ Pt. Aware? Yes No
 Patient notified by _____ Notified: In person By phone