ENVISION
MEDICAL IMAGING

Myocardial Perfusion
Patient Information, Consent and Checklist

MYOCARDIAL PERFUSION SCAN and PREPARATION

IMPORTANT: PLEASE READ CAREFULLY AND FOLLOW INSTRUCTIONS CLOSELY

Please follow these instructions carefully, as incorrect preparation may result in your test being rescheduled.

1. **NO CAFFEINE PRODUCTS** for one full day (24 hours) prior to the test. No coffee (including decaf), tea/herbal tea, chocolate, milo, ovaltine, cola/soft drinks or energy drinks.
2. **FAST FOR 4 HOURS** prior to your appointment. Small amounts of plain water may be taken during this period if required. If you are diabetic, we will discuss management when confirming your booking.
3. Please inform our staff if you take oral persantin, tablets for asthma, or Viagra-type drugs as these may need to be stopped before your study. Your referring doctor will inform you if any of your cardiac medications need to be ceased (i.e. Beta blockers).

A staff member will call you or your designated contact to confirm these instructions 2 days before your appointment.

Wear comfortable clothing and shoes appropriate for exercise. Please do not apply talcum powder or moisturiser to your chest.

Bring a list of your medications, your referral, this information form, and your Medicare card.

Please do not bring children with you. You should limit contact with small children for 6 hours after each appointment.

The first appointment takes 1 ½ - 2 hours, and includes a stress test, which involves walking on a treadmill. Exercise testing involves a risk of about 1 in 10 000 of heart attack or death.

A medication called Dipyridamole will be used if exercise is not possible. Side effects to this medication can include headache, flushing, shortness of breath, chest discomfort, dizziness and nausea. The risk of serious Dipyridamole-induced side effects is very low and is comparable to that of exercise stress testing.

During the stress test, the doctor will inject a small amount of a radioactive tracer; you will not experience any side effects from this injection.

Following this, a scan of your heart will be performed, after which you will be able to leave the department. You may resume eating and drinking as normal. If you do not wish to leave the department, please bring something to eat with you. The technologist will give you a time to return for the second appointment.

The second (rest) appointment will take approximately 30 mins. The scan will be repeated.

Medicare will rebate this test. We offer direct billing, with no out-of-pocket costs to you on the day.

For further information visit
www.envisionmi.com.au/nucmed-heart-scan
or call 6382 3888

I have read the information provided regarding my procedure. I understand the information and have had the opportunity to ask questions about what is going to happen, the reasons for the procedure being performed, and the associated risks. I agree to have the procedure performed.

Patient Name			Date
Patient Signature *(or signature of legal guardian)*			
Signature of MIT/Radiologist		Signature of MIA/Nurse	

OFFICE USE ONLY

ANTICOAGULANTS ☐ Yes ☐ No DIABETIC ☐ Yes ☐ No ALLERGIES ☐ Yes ☐ No CAFFEINE FREE ☐ Yes ☐ No

PATIENT ID CHECKLIST

NAME confirmed ☐ DOB confirmed ☐ GENDER confirmed ☐ ADDRESS confirmed ☐

PROCEDURE CHECKLIST

TYPE confirmed ☐ CONSENT confirmed ☐ TIME OUT ☐ EMI Staff _____

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Patient Height: **Patient Weight:**

Have you had a heart scan before?			YES		NO
If YES, where and when?					
Reason for heart scan? eg. chest pain, recent heart attack, etc.					
Do you smoke?	YES	NO	Have you ever smoked?	YES	NO
If YES, how many per day?			If YES, when did you stop?		
Have you ever had a heart attack? When			YES		NO
Do you have high blood pressure?			YES		NO
Do you have high cholesterol? Level (if known)			YES		NO
Is there a family history of heart problems?			YES		NO
If YES, please describe					
Do you have Diabetes?			YES		NO
If YES, how is it controlled? eg. pills, injections					
Do you experience chest pain or discomfort?			YES		NO
Do you experience breathlessness?			YES		NO
Do you have problems walking? eg. calf pain, etc.			YES		NO
If YES, please describe					
Have you ever had any medical intervention on your heart?			YES		NO
If YES, please describe					
Please list any past medical illnesses					
Please list ALL current medication					
Please list drug allergies					
What time did you last consume caffeine (coffee/tea/chocolate etc)?					
FEMALE PATIENT ONLY: Are you pregnant or currently breastfeeding?				YES	NO
MALE PATIENT ONLY: Are you currently taking Viagra or similar medication?				YES	NO

OFFICE USE ONLY

MEDICATION	DOSE	ROUTE	DR SIGNATURE	GIVEN BY	DATE/TIME
Dipyridamole		IV			
Aminophylline		IV			