PETERSON HEALTH

DOBUTAMINE STRESS TEST CONSENT FORM

In order to help Dr. _____ to determine an appropriate plan of therapy, I hereby consent to undergo the following procedure of **Dobutamine Stress** for **Radionuclide Imaging** of the **Heart**.

PURPOSE AND PROCEDURE: Dobutamine Myocardial Perfusion studies of the heart are employed to assess the presence and severity of coronary artery disease. The Study may be performed instead of, or in conjunction with, conventional methods of exercise stress testing.

The study requires insertion of two intravenous needles which may cause minor discomfort from the needle sticks. During this study, heart rate, blood pressure, and electrocardiogram will be carefully monitored. Potential risks or side effects include weakness, chest pain, nausea, and vomiting. Dobutamine can increase the systolic blood pressure and heart rate. Should side effects from the drug occur the drug will be immediately discontinued.

Every effort will be made to minimize any complication by observation and by the availability of equipment and personnel to deal with unusual situations which may arise.
Dobutamine's maximum effect occurs in ten to twenty minutes and is gone in approximately six minutes.

Since the administration of radiopharmaceuticals to a pregnant woman could result in unnecessary risks to an unborn fetus, pregnant females will be excluded from this study.

I have been informed that, although unlikely, should I suffer any injuries as a result of participation in this activity, all of the necessary medical facilities will be available for treatment. I understand there is no provision for hospital expenses or other financial compensation for injury, even though it is unlikely to occur. I hereby release Peterson Regional Medical Center, its personnel and any physicians, from all responsibility or liability for the ill effects, if any, resulting from the above procedure or treatment.

Signature of patient: _____ Date: _____

Signature of parent/guardian: _____ Date: _____

Signature of witness: _____ Date: _____

I have explained the risks and benefits of this procedure and I believe the patient understands the risks.

Physician's Signature: _____ Date: _____ Time: _____