McLaren
CARO REGION

Name: _____ MR #: _____

Referring Physician _____

INFORMED CONSENT

PURPOSE and PROCEDURE:

I hereby voluntarily consent to perform an exercise or pharmalogic (medication) induced stress test in order to evaluate the functional performance and capacity of the heart as requested by my physician. I understand that I will be questioned regarding my health status. A routine electrocardiogram will be obtained prior to the exercise testing and I might be examined by a trained clinician prior to the test depending upon the information available at that time to exclude any apparent contra-indications to the testing procedure. The stress test will be performed with a treadmill or pharmalogical agent until the desired increase in heart rate is achieved, muscular fatigue occurs or symptoms indicating possible adverse reactions are noted. The entire testing procedure will be closely monitored by the technician in attendance with an electrocardiogram and the blood pressure recorded at appropriate intervals.

I understand the risks of this procedure include occasional disorders of the heart rhythm, abnormal blood pressure response, light headed or faint feeling and very rarely (less than one chance in a thousand) of a heart attack occurring as the result of the stress test. Professional supervision will be present to provide appropriate precautionary measures as well as treatment that becomes necessary for any complications that occur. I understand that in the event of any adverse reaction, hospitalization for appropriate studies and treatment may be necessary and I accept responsibility for it if it becomes warranted in the judgment of the attending physicians. I also understand that if any changes are revealed in my test, the clinician in attendance may request that I return the following day for an electrocardiogram and I agree to do so.

I understand that the testing will provide useful diagnostic information which will facilitate appropriate treatment for me by my physician.

I am aware that I have the right to withdraw from the test at any time.

_____ _____
Signature of Patient Signature of Witness

_____ _____
Date Time

CARDIO PULMONARY DEPARTMENT
EXERCISE LABORATORY

FORM: CP 4
REV: 7-11-16