DALLAS
Heart & Vascular
CONSULTANTS

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Patient Name: **Date:**
Arrival Time:
Location of test: **916 E. US Highway 67** **Test Time:**
Duncanville, TX 75137

INSTRUCTIONS FOR NUCLEAR STRESS TEST

- Do not eat or drink 4 hours prior to the test
- Do not take caffeine **after 8 P.M.** the night prior to the test. This includes coffee, tea, chocolate, cocoa, colas, and medications containing caffeine such as Anacin, Exedrin, Theophylline, etc.
- If you use **insulin**, take half of the regular dose on day of test
- If you take oral medicine for diabetes, do not take it on day of test:_____
- If you take **beta-blocker** such as Toprol (Metoprolol), Atenolol, Inderal (Propranolol) , Coreg(Carvedilol) or Nadolol AND Bystolic, hold the medicine for 24 hours prior to the test. **(BRING BLOOD PRESSURE MEDICATIONS WITH YOU)**
- If you wear a **Nitro Patch**, please remove 2 days prior to your test.
- Continue all other medicines as scheduled. You may take medicines with sips of water.
- Wear comfortable clothing and walking shoes. **WOMEN: NO DRESSES PLEASE**
- **It will take approximately 3-4 hours to complete the test. You will be allowed to eat after the stress part of the test is completed.**
- Please do not apply lotion before the test * Please do not bring children to appointment.
- Please bring a sandwhich and a caffeine drink if you do not drink coffee. You can have snack and caffeine after the fasting part of the test is complete. _____

- **IMPORTANT NOTE: Your dose will not be ordered until we have verbally confirmed your appointment. If you do not verbally confirm, we may not be able to complete your test as scheduled. The radioisotope dose for this test is ordered specifically for you and cannot be returned. We will be collecting a $140 deposit at the time your test is scheduled. If you are unable to make your appointment, you must give our office 24 hours notice or you will be charged for the radioisotope.** **After Hours Telephone Number: 603-556-1643**

Type of Payment: Check Credit Card Cash

Name on Card: _____ **Credit Card #:** _____

CV #: _____ **Exp. Date:** _____ **Billing Zip:** _____ **Check Number:** _____

I have read the above information and understand my responsibilities and obligations. By signing this form, I agree to comply with the above.

Patient Signature: _____ Date: _____