STRESS NUCLEAR TESTING INSTRUCTIONS

Patient Name:_____ **Acct #**_____

Appt Date:_____ **Time :**_____

Testing Location: ☐ 1830 Town Center Dr., Suite 405, Reston, VA 20190 **703-481-9191**

☐ 3025 Hamaker Court, Suite 100, Fairfax, VA 22031 **703-641-9161**

☐ 44084 Riverside Pkwy., Suite 150, Lansdowne, VA 20176 **703-858-3185**

Exam Time: Approximately 3 hours and 45 minutes
Exam area tends to be cold. You may want to bring a sweater or blanket.

24 HOURS BEFORE YOUR TEST

- **NO** smoking
- **NO** beta blockers or calcium channel blockers if walking on a treadmill (unless otherwise instructed by your physician). **[see reverse side for details]**

12 HOURS BEFORE YOUR TEST

NO CAFFEINE coffee, decaf coffee, tea of any kind, soda, food or drink containing chocolate
NO medications containing caffeine such as (Anacin, Cafergot, Darvon Compound, Esgic, Exedrin, Fioricet, Fiorinal, Migraine Medications, No-Doz, Norgesesic, Norgesic Forte, Vivarin (check labels of OTC medications)

THE DAY OF THE TEST

- **DRINK PLENTY OF WATER BEFORE COMING INTO THE OFFICE**
- Nothing to eat 6 hours before the test. You **MAY** drink water in any amount.
- Please wash chest area and avoid oil, lotion, powder and perfume.
- Wear a comfortable two-piece outfit; avoid wearing dresses, jumpsuits or shirts with metallic buttons or zippers on the chest area. Wear comfortable walking shoes.
- Bring a current list of medications and dosages.
- If you are **diabetic,** please talk with your ordering physician about restrictions.
- If you have an Albuterol inhaler, or oxygen please bring it with you
- Bring a snack. We will allow you to eat something during a specific time of the test.
- **Bring your scheduled cardiac medications with you, to take as directed by the technician after the test.**

Patient Agreement for Stress Myocardial Perfusion Study

I have been advised, understand, and agree that if I do not keep the appointment for the Stress Myocardial Perfusion study which I have confirmed for the date listed below, I will be personally responsible to pay a fee of $400.00 for reimbursement to the practice for the radiopharmaceutical which are needed to be ordered and purchased in advance for the test I have scheduled.

I understand that this fee will be waived only if I have provided Cardiac Care Associates with notice of cancellation of this appointment by 10:00 am the business day prior to the test. For all Monday appointments, cancellation notice must be made the Friday prior to the test no later than 10:00am.

Patient Signature:_____ **Date:**_____

TURN OVER→

Do not take the following medications 24 hours prior to your test

Aerolate	Slo-Bid Gyrocaps	Theo-Dur
Aggrenox	Slo-Phyllin Grocaps	Theo-Dur Sprinkle
Bronkodyl	Sustaire	Theolair-SR
Constant-T	Theo-24	Theospan- SR
Elixophyllin SR	Theobid Duracap	Theovent-L.A.
Persantine (Dipyridamole)	Theobid Jr. Duracap	Trental
Quibron-SR	Theoclear L.A.	Uniphyl
Respid	Theochron	

<u>If walking on a treadmill</u>
Do not take the following medications after 12 noon the day before

Acebutolol	Diltiazem	Sotalol * check with your Doctor*
Atenolol	Inderal, Inderal LA	Tarka
Betapace	Inderide, Inderide LA	Tenormin
Betaxolol	Isoptin	Tenoretic
Bisoprolol	Kerlone	Tiazac
Blocadren	Labetalol	Timolol
Bystolic	Levatol	Toprol, Toprol XL
Calan	Lopressor, Lopressor HCT	Trandate
Cardizem	Metoprolol	Verapamil
Cartia	Nadolol	Verelan (SR)
Carvedilol	Nebivolol	Visken
Coreg	Penbutolol	Zebeta
Corgard	Pindolol	Ziac
Covera	Propanolol	
Dilacor	Sectral	

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