INFORMED CONSENT FOR IV PERSANTINE STUDY

YOUR DOCTOR HAS REQUESTED THAT YOU UNDERGO AN IV DIPYRIDAMOLE (PERSANTINE) PHARMACOLOGIC STRESS TEST, WITH MYOCARDIAL PERFUSION IMAGING TO STUDY YOUR HEART'S BLOOD FLOW PATTERN. THE TEST INVOLVES GIVING YOU A DIAGNOSTIC MEDICATION (DIPYRIDAMOLE) THROUGH AN IV IN YOUR ARM, FOR FOUR MINUTES. YOU WILL RECEIVE A HEART BLOOD FLOW MARKER (RADIOTRACER) THROUGH YOUR IV THREE MINUTES AFTER THE DIPYRIDAMOLE IS GIVEN. A SHORT TIME (5 – 60 MINUTES) AFTER THE RADIOTRACER INJECTION, YOU WILL LIE DOWN AND HAVE PICTURES TAKEN OF YOUR HEART.

IV DIPYRIDAMOLE STRESS TESTING IS USED IN PLACE OF EXERCISE STRESS TESTING TO LOOK FOR EVIDENCE OF BLOCKAGE OF BLOOD FLOW IN YOU HEART'S ARTERIES. THE TEST HAS POSSIBLE RISKS AND SIDE EFFECTS. THERE IS A RISK OF YOUR HAVING CHEST PAIN AND/OR REVERSIBLE ECG CHANGES. THE CHANCES OF MORE SERIOUS RISKS – HEART ATTACK, SERIOUS RHYTHM PROBLEMS OR DEATH ARE EXTREMELY LOW. IV DIPYRIDAMOLE CAN ALSO CAUSE LIGHT HEADEDNESS, A FLUSHED FEELING, HEADACHE OR A QUEASY STOMACH, BUT MORE THAN HALF OF PATIENTS EXPERIENCE NO SIDE EFFECTS WHATOSEVER. IF YOU DO HAVE CHEST PAIN, ECG CHANGES OR ANY OTHER SIDE EFFECTS, YOU WILL BE TREATED WITH A MEDICATION CALLED AMINOPHYLLINE, WHICH NEUTRALIZES THE EFFECTS OF THE DIPYRIDAMOLE IN 1 – 3 MINUTES. EQUIPMENT AND TRAINED PERSONNEL ARE AVAILABLE TO DEAL WITH UNUSUAL SITUATION SHOULD THEY ARISE.

TO PERFORM THE TEST AS SAFELY AS POSSIBLE, A PHYSICIAN TRAINED IN CARDIAC STRESS TESTING AND 1 – 2 TECHNOLOGISTS TRAINED IN THE PERFORMANCE OF THE TEST WILL BE WITH YOU DURING THE STUDY. YOU WILL HAVE A BRIEF CARDIAC HISTORY AND EXAMINATION PERFORMED TO EXCLUDE ANY CONTRAINDICATIONS TO PERFORMING THE TEST. YOUR BLOOD PRESSURE AND ECG WILL BE RECORDED BEFORE, DURING AND AFTER THE DIPYRIDAMOLE INFUSION. YOU WILL BE MONITORED CONTINUOUSLY DURING THE TEST. YOU SHOULD REPORT ANY SYMPTOMS TO THE DOCTOR OR TECHNOLOGISTS.

I UNDERSTAND THAT RECORDS OF THE TEST WILL BE KEPT AT DELAWARE CARDIOVASCULAR ASSOCIATES, AND THAT I MAY WITHHOLD RESULTS FROM NON-MEDICAL PERSONS (EMPLOYERS, INSURANCE AGENTS, ETC.). I PERMIT REGISTRATION OF MY NAME FOR POSSIBLE FOLLOW UP PURPOSES.

HAVING READ THE ABOVE, AND UNDERSTANDING THE INDICATIONS FOR THE PROCEDURE, THE METHOD IN WHICH IT IS TO BE PERFORMED, AND THE POSSIBLE COMPLICATIONS, I HEREBY ACCEPT THE RISKS AT STATED AND AGREE TO PERFORM THE IV DIPYRIDAMOLE (PERSANTINE) PHARMACOLOGIC STRESS TEST.

PATIENT SIGNATURE _____ DATE _____

THE ABOVE PATIENT HAS BEEN EXAMINED BY ME TODAY AND I HAVE FOUND NO CONTRAINDICATIONS TO IV PERSANTINE TESTING. HE/SHE HAS BEEN GIVEN THE OPPORTUNITY TO HAVE HIS/HER QUESTIONS ABOUT THE TEST ANSWERED.

WITNESS SIGNATURE _____ PHYSICIANS SIGNATURE _____