



200 E. Sheridan Rd.,
Melbourne, Florida 32901
(321) 725-4500

NUCLEAR MEDICINE DEPARTMENT

Dr. _____ has ordered a Myocardial Perfusion Stress Test on patient _____.

Acct. No. _____ on (Day & Date) _____ at (Time) _____.

()-ExerciseTreadmill ()-Adenoscan ()-Persantine ()-Dobutrex

Please check in with the Receptionists at Radiology.

PATIENT PREP INSTRUCTIONS:

*** DO NOT EAT OR DRINK ANYTHING FOR 4 HOURS BEFORE THE TEST.**

*** FOR PERSANTINE/ADENOSCAN TESTING - NO CAFFEINE OR CHOCOLATE FOR 24 HOURS PRIOR TO TEST.**

*** WEAR COMFORTABLE SHOES AND CLOTHING.**

*** MEDICATIONS:**

() DO NOT TAKE _____ FOR _____ HRS./DAYS PRIOR THE TEST.

() CONTINUE ALL MEDICATIONS UP TO TIME OF TEST.

Have you had a previous stress test?	Yes (when & where?) _____	No
Have you ever had a heart attack?	Yes (how many?) _____	No
	Date of most recent? _____	

Have you ever had a heart catheterization?	Yes _____
	When? _____

Have ever had an angioplasty?	Yes _____
	When? _____

Have you ever had heart surgery?	Yes _____
	When? _____

Have you had any pain or discomfort above your waist area in last 12 mths?	_____
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Height: _____ Weight: _____

List All Medications Taken Over Last 12 mths.: _____

Date/Time Last Taken: _____ Medication Allergies: _____

IF YOU HAVE ANY QUESTIONS, PLEASE CALL US AT (321)725-4500 x842.