

## Exercise Stress Test

Location:

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex:  M  F  I

### A. Interpreter / cultural needs

- An Interpreter Service is required?  Yes  No  
 If Yes, is a qualified Interpreter present?  Yes  No  
 A Cultural Support Person is required?  Yes  No  
 If Yes, is a Cultural Support Person present?  Yes  No

### B. Condition and treatment

The doctor has explained that you have the following condition: *(Doctor to document in patient's own words)*

.....

.....

This condition requires the following investigation. *(Doctor to document - include site and/or side where relevant to the procedure)*

.....

.....

The following will be performed:

Before the test starts, an electrocardiogram (ECG) is taken. This is a paper recording of your heart beat.

Next, your heart is exercised or 'stressed'. If you can walk easily, you can walk on the treadmill. The speed and slope of the treadmill will increase every 3 minutes. This makes your heart do more work. The test will be stopped if you have chest pain, become very tired or very short of breath (puffed).

If you feel unwell you should tell staff at once.

### C. Risks of an exercise stress test

There are risks and complications with this investigation. They include but are not limited to the following.

**Common risks and complications (more than 5%)** include:

- Mild angina.
- Shortness of breath.
- Musculoskeletal discomfort.

**Uncommon risks and complications (1 – 5%)** include:

- Low blood pressure.

**Rare risks and complications (less than 1%)** include:

- Fainting.
- Abnormal heart rhythm that continues for a long time. This may need an electric shock to correct.
- Build up of fluid in the lungs. You may need medication to treat this.
- Severe chest pain. This is treated with medications.

- Heart Attack
- Death as a result of this procedure is extremely rare.

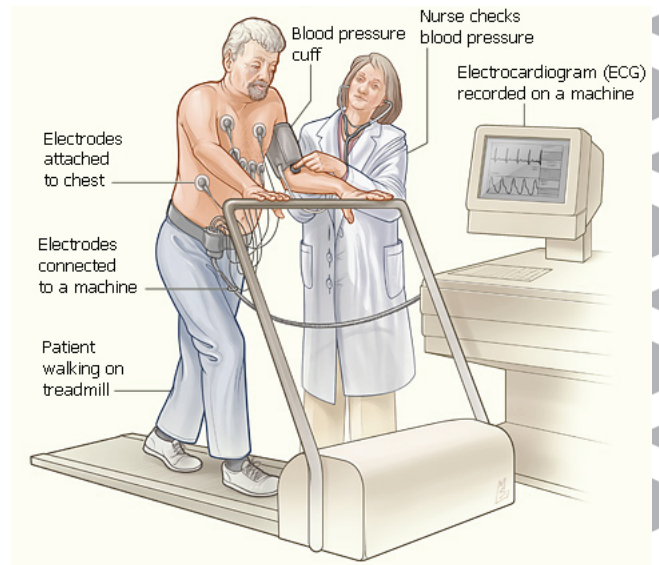


Fig 1. National Heart, Lung and Blood Institute

### D. Significant risks and investigation options

*(Doctor to document in space provided. Continue in Medical Record if necessary.)*

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### E. Risks of not having this investigation

*(Doctor to document in space provided. Continue in Medical Record if necessary.)*

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### F. Patient consent

I acknowledge that the doctor has explained;

- my medical condition and the proposed investigation, including additional treatment if the doctor finds something unexpected. I understand the risks, including the risks that are specific to me.
- other relevant procedure options and their associated risks.
- my prognosis and the risks of not having the procedure.
- that no guarantee has been made that the procedure will improve my condition even though it has been carried out with due professional care.
- if immediate life-threatening events happen during the procedure, they will be treated based on my discussions with the doctor or my Acute Resuscitation Plan.
- a doctor other than the Consultant may conduct the procedure/treatment. I understand this could be a doctor undergoing further training.

#### I have been given the following Patient Information Sheet/s:

##### Exercise Stress Test

- I was able to ask questions and raise concerns with the doctor about my condition, the proposed investigation and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction.
- I understand I have the right to change my mind at any time, including after I have signed this form but, preferably following a discussion with my doctor.
- I understand that image/s or video footage may be recorded as part of and during my investigation and that these image/s or video/s will assist the doctor to provide appropriate treatment.

On the basis of the above statements,

### I request to have the procedure

Name of Patient: .....

Signature: .....

Date: .....

#### Patients who lack capacity to provide consent

Consent must be obtained from a substitute decision maker/s in the order below.

Does the patient have an Advance Health Directive (AHD)?

Yes ▶ Location of the original or certified copy of the AHD: .....

No ▶ Name of Substitute Decision Maker/s: .....

Signature: .....

Relationship to patient: .....

Date: ..... PH No: .....

Source of decision making authority (tick one):



Tribunal-appointed Guardian

Attorney/s for health matters under Enduring Power of Attorney or AHD

Statutory Health Attorney

If none of these, the Adult Guardian has provided consent.

### G. Doctor/delegate statement

I have explained to the patient all the above points under the Patient Consent section (G) and I am of the opinion that the patient/substitute decision-maker has understood the information.

Name of Doctor/delegate: .....

Designation: .....

Signature: .....

Date: .....

### H. Interpreter's statement

I have given a sight translation in

.....  
(state the patient's language here) of the consent form and assisted in the provision of any verbal and written information given to the patient/parent or guardian/substitute decision-maker by the doctor.

Name of Interpreter: .....

Signature: .....

Date: .....

