MedStar Georgetown University Hospital

MedStar Georgetown University Hospital
Division of Pulmonary and Critical Care Medicine
Pulmonary Function Lab
3800 Reservoir Rd., NW
PHC Building, Fifth Floor, 5030E
Washington, DC 20007
202-444-8830 **SCHEDULING**
202-444-7038 **LAB**

Pulmonary Exercise Testing

Patient Name: _____ Appointment Date and Time: _____

You have been scheduled for an **EXERCISE** test. This test usually takes about one to two hours. If you need to bring children with you to the appointment, please bring someone to supervise them. They will not be allowed in the stress lab with you. If you need an interpreter, please let the staff know. Family members cannot act as interpreters during this test.

YOU WILL NEED TO WEAR COMFORTABLE CLOTHING (SWEATS, SHORTS) AND SNEAKERS OR WALKING/RUNNING SHOES. Shirts should have short or no sleeves. Females should wear a sports bra and/or a comfortable bra and loose-fitting top. No jeans please.

1. Instructions for medications:
   a. Hold albuterol (Provental®, Ventolin®), if possible.
   b. Use regular medications.
2. **Very light meal and water only** four hours prior to the test. **DIABETICS REQUIRING INSULIN SHOULD CONSULT THEIR PHYSICIAN FOR SPECIFIC INSTRUCTIONS**.
3. Avoid **caffeine** on the day of the test. This includes coffee or tea that is brewed, instant or iced. No colas or other soft drinks that contain caffeine. No chocolates, including candies, frosting, cookies, pies, cocoa and chocolate milk. No aspirin that contains caffeine, such as Anacin® and Excedrin®.
4. If you are wheezing within 24 hours of the test or have had a respiratory infection within the past six weeks, contact your physician and reschedule the test. Call **202-444-4982** or **202-444-8830, option 2**, to reschedule.
5. If you have or had any of the following conditions, do not schedule the test. Notify the physician ordering the test.
   a. Heart attack or stroke with the last three months
   b. Uncontrolled hypertension; Blood pressure greater than 200/100
   c. Aortic or cerebral aneurysm
   d. Epilepsy
   e. Cardiovascular disease accompanied by bradycardia (slow heart rate) or heart block
   f. Myasthenia gravis
   g. If you are pregnant and/or nursing
6. On the morning of the test, complete and sign the patient questionnaire. Bring the completed, signed form, your order and any other paperwork your physician has provided for testing. **Please do not use oils or lotions on your body that morning.**

IMPORTANT: PLEASE NOTE

If you are not a current patient of the Pulmonary Division at MedStar Georgetown University Hospital, you will need to bring or fax (**202-444-4987**) your prior pulmonary function tests, six-minute walks or stress tests, as well as **a brief history and physical from the doctor that has ordered the tests**.

No testing will be started until this information is received.

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Pulmonary Exercise Pre-Test Questionnaire

Patient Name: _____ ID Number: _____

Age: _____ Height: _____ Weight: _____

Reason for Test: _____

Medical History

1. Has a physician ever told you have asthma/lung disease? YES/NO
2. Did you have respiratory disease as a child? YES/NO
3. Have you experienced and of the following conditions?

Wheezing	YES/NO	Diabetes	YES/NO
Chest tightness/pain	YES/NO	Heartburn	YES/NO
Shortness of breath	YES/NO	Heart attack	YES/NO
Rapid heartbeat	YES/NO	Heart murmur	YES/NO
Abnormal EKG	YES/NO	Arthritis	YES/NO
Dizziness/fainting	YES/NO	Joint pain	YES/NO
High cholesterol	YES/NO		

4. If you are a smoker, when did you last smoke? _____
   How much do you smoke? _____ per day or week _____
   If you are a former smoker, when did you quit? _____
5. Have you had a respiratory infection within the last six weeks? YES/NO
6. Have you had a heart attack or stroke within the last three months? YES/NO
7. Do you have high blood pressure greater than 200/100? YES/NO
8. Have you been told that you have a aortic or cerebral aneurysm? YES/NO
9. Are you pregnant and/or nursing? YES/NO
10. Are you using any of the following medications: Lepressor®, Atenolol®, Propranolol®, Inderal®, Nardolol®, Corzide®, Inderide®, Hetopic®, Timoptic®? YES/NO
11. Do you have:

Epilepsy	YES/NO	Urinary tract obstruction	YES/NO
Peptic ulcer disease	YES/NO	Myasthenia gravis	YES/NO
Thyroid disease	YES/NO		

12. Have you ever had any of the following procedures?

Angiogram	Date: _____
Heart catherization	Date: _____
Angioplasty/stent	Date: _____
Heart bypass surgery	Date: _____
Valve replacement	Date: _____
Pacemaker	Date: _____

13. Are you currently involved in a regular exercise program? YES/NO

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Pulmonary Exercise Pre-Test Questionnaire

List all of the medications you have taken in the last 48 hours for asthma, breathing problems, hay fever, blood pressure, allergies or stomach problems, and the total number of days since your last dose for each medication. If you need more space, use another page.

Drug	Date and time of last dose

Patient Signature:

Date:

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Consent for Clinical Study Pulmonary Exercise Test

1. **Explanation of the test**
   You will perform an exercise test on an electronically braked bicycle or a motor-driven treadmill. The exercise intensity will begin at a low level and will gradually increase. We may not stop the test at any time because of signs of fatigue or other response, which the physician considers significant. You may request to stop the test at any time because of fatigue or other feelings of discomfort.

2. **Risks and discomforts**
   There exists the possibility of certain changes occurring during the test. They include abnormal blood pressure response, fainting, fast, slow or irregular heartbeat and, in rare instances, heart attack. Every effort will be made to minimize these risks; emergency equipment and trained personnel are available to handle any situations that may arise.

3. **Benefits**
   The results obtained from this exercise test may assist in the diagnosis and treatment of your illness. The results may be useful in evaluations of the types of physical activity in which you might participate with normal (small) risk.

4. **Educational benefit**
   MedStar Georgetown University Hospital is a teaching institution and, for the purpose of advancing education, you may be asked if an observer may be admitted to the procedure room. With your permission, photographs and/or videotapes of the procedures may be taken for medical, scientific or educational purposes. The information obtained may be used and published for scientific purposes. Your identity is not revealed in any way by pictures or by the descriptive text accompanying them. Your privacy will be held in the strictness of confidence.

Freedom of Consent:
To determine my cardiopulmonary response to exercise, I voluntarily agree to engage in this exercise test. My signature on the form indicates that I have read this form, I understand the test procedures and the associated risks and all of my questions have been answered to my satisfaction.

INFORMATION BELOW (TO BE FILLED OUT AT TIME OF TEST)

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

Team Pause Date: _____ Time: _____ Signature: _____

Correct patient identity
Agreement on procedure to be done
Availability of all anticipated equipment and/or supplies