



CARDIOPULMONARY

Questions the Central Scheduler May ask when scheduling an exam:

DOES THIS PATIENT HAVE ANY SPECIAL NEEDS?

HOW MUCH DOES THE PATIENT WEIGH? PLEASE SPECIFY POUNDS OR KILOGRAMS.

HOW TALL IS THE PATIENT?

IF FEMALE, IS PATIENT PREGNANT?

IS PATIENT 14 OR UNDER? IF NOT USE ORDER CODE ECHO FOR ADULT ECHOCARDIOGRAM.

PLEASE HAVE PATIENT BRING A CURRENT LIST OF MEDICATIONS INCLUDING NON-PRESCRIPTION AND HERBALS.

WHAT INSURANCE DOES THE PATIENT HAVE AND DOES IT REQUIRE PRE-CERTIFICATION? IF YES, TYPE NUMBER HERE.



HOLTER MONITOR/TELEHEART/EVENT MONITOR

Appointment Date/Time: _____

Instructions:

Please arrive 15 minutes prior to appointment time.

Please allow up to 45 minutes for this exam.

DO NOT APPLY ANY LOTION OR OIL TO YOUR CHEST AREA.

BRING A LIST OF ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING OVER THE COUNTER AND HERBALS.

Be sure you bring the physician order with you on the day of your exam or have your physician fax it to: 217-479-5875

If you have any questions regarding your test please call the Cardiopulmonary Dept at 217-245-9541 ext 3379. If you have questions regarding your appointment time or need to reschedule this appointment, call Central Scheduling at 217-479-5696.

The Central Scheduling Department hours are Monday – Friday 7am – 5:30pm.



METHACHOLINE CHALLENGE

Appointment Date/Time: _____

Instructions:

Please arrive 15 minutes prior to appointment time.

Please allow up to 1 hour for this exam.

This test cannot be done on children under the age of 7.

DO NOT USE INHALERS OR BREATHING MEDICATIONS THE MORNING OF THE TEST.

BRING A LIST OF ALL THE MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING OVER THE COUNTER AND HERBAL.

IF YOU ARE PREGNANT THIS TEST CANNOT BE COMPLETED.

Please be sure you to bring the physician order with you the day of your exam or have your physician fax it to: 217-479-5875

If you have any questions regarding your test please call the Cardiopulmonary Dept at 217-245-9541 ext 3379. If you have questions regarding your appointment time or need to reschedule, please call Central Scheduling at 217-479-5696.

The Central Scheduling Department hours are Monday – Friday 7am – 5:30pm.



ECHOCARDIOGRAM

Appointment Date/Time: _____

Instructions:

Please arrive 15 minutes prior to appointment time.

Allow up to 45 minutes for this exam.

BRING A LIST OF ALL YOUR MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING OVER THE COUNTER AND HERBALS.

Be sure you bring the physician order with you the day of your exam or have your physician fax it to: 217-479-5875

If you have any questions regarding your test please call the Cardiopulmonary Dept at 217-245-9541 ext 3379. If you have questions regarding your appointment time or need to reschedule, please call Central Scheduling at 217-479-5696.

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NUCLEAR MED NON-WALKING/PERSANTINE STRESS TEST

Appointment Date/Time: _____

A Pharmacological stress test is a test in which you will be given a medicine to stress your heart. A radioactive tracer is administered through an IV before resting pictures and again during the stress test. Pictures are taken again following the stress test.

The purpose of the stress test is to assist in evaluating blood flow through your heart muscle.

This type of stress test is used for patients who are unable to walk on the treadmill or are unable to walk for very long. If possible, you may be asked to walk for about one minute at one mile per hour and no elevation to raise your heart rate.

EKG's and vital signs are monitored during the test. A physician will be present in the room at all times during the stress test.

To prepare for your stress test, please follow these instructions:

Allow up to 3 hours for the exam.

BRING A LIST OF ALL YOUR CURRENT MEDICATIONS, INCLUDING OVER THE COUNTER AND HERBALS.

DO NOT TAKE THEOPHYLINE OR XANTHINE MEDICATION FOR 48 HOURS BEFORE YOUR STRESS TEST.

DO NOT EAT OR DRINK ANYTHING CONTAINING CAFFEINE FOR 24 HOURS BEFORE YOUR TEST (INCLUDING COFFEE, TEA, SODA OR CHOCOLATE).

DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT THE NIGHT BEFORE YOUR EXAM. HOWEVER, DIABETIC PATIENTS MAY EAT A VERY LIGHT BREAKFAST TO MAINTAIN BLOOD SUGAR, IF NECESSARY (EXAMPLES: DRY TOAST AND SMALL JUICE).

TAKE MEDS WITH SIPS OF WATER. DIABETIC PATIENTS: DO NOT TAKE YOUR DIABETES MEDS IF YOU HAVE NOT EATEN.

WEAR COMFORTABLE SHOES.

Complete the attached questionnaire and bring it with you to your appointment. If you have any questions regarding your test please call the Cardiopulmonary Dept at 217-245-9541 ext 3379. If you have questions regarding your appointment time or need to reschedule, please call Central Scheduling at 217-479-5696.

The Central Scheduling Department hours are Monday – Friday 7am – 5:30pm.



QUESTIONNAIRE FOR NUCLEAR STRESS TEST

Please complete this form, prior to your exam, and bring with you to your appointment.

Patient Name: _____ **Height:** _____ **Weight:** _____

Reason for doing stress: _____
 _____ Atypical chest pain _____ Palpitations _____ Heart Failure _____ Syncope
 _____ Angina _____ R/O MI _____ Pre-OP _____ Physical

If chest pain, describe: _____
Does it go to the: _____ Back? Is the pain _____ Sharp? Do you get _____ Nauseated?
 _____ Jaw? _____ Dull? _____ Sweaty?
 _____ Arms? _____ Heaviness? _____ Short of breath?
 _____ Shoulders? _____ Pressure?

What are you doing when this occurs? _____ How long does it last? _____
 How long have you had these symptoms? _____

Have you ever had a previous stress test? _____ If yes, when? _____
 Have you ever had a heart attack? _____ If yes, when? _____
 Have you ever had heart surgery? _____ If yes, when and what? _____
 Do you smoke? ___yes ___no If yes, how much? _____ For how long? _____
 If you have quit smoking, when did you quit? _____ How long had you smoked? _____
 Do you consume alcohol? (please circle one).....Never.....SeldomOccasionalFrequent.....
 Do you have any allergies to medicine? ___no ___yes If yes, list: _____

What is your occupation? _____

Do you have any of the following? (If yes, please check)

_____ Diabetes _____ COPD/Asthma _____ High Cholesterol _____ CHF _____ High Blood Pressure

List medications you are currently taking: _____,
 _____,
 _____,

Past Medical History/ Surgical: _____,
 _____,
 _____,

Family History: Answer the following questions for parents. If unknown, put (?)

| | | | | | | |
|------------------------|-------------------------|--------------------|--------------------|----------|-------------------------|-------------------|
| Living or Deceased? | Age now or at death? | Cause of Death? | Heart Problems? | Diabetes | High Blood Pressure? | Cancer? Where? |
|------------------------|-------------------------|--------------------|--------------------|----------|-------------------------|-------------------|

Mother: _____
 Father: _____
 Do you have any brothers and/or sisters? _____ If yes, how many? _____
 Do they have any health problems? ___no ___yes If yes,
 Please Describe: _____



NUCLEAR MED WALKING/TREADMILL STRESS TEST

Appointment Date/Time: _____

A Dual Isotope (walking) stress is a test in which you will walk on a treadmill to increase your heart rate. A radioactive tracer is administered through an IV needle before resting pictures and again during the stress test. Pictures are taken again following the stress test. The purpose of this stress test is to assist in evaluating blood flow through your heart muscle. EKG's and vital signs are monitored during the test. A physician will be present in the room at all times during the stress test.

To prepare for your test, please follow these instructions:

Allow up to 3 hours for this exam.

BRING A LIST OF ALL YOUR MEDICATIONS THAT YOU ARE CURRENTLY TAKING, INCLUDING OVER THE COUNTER AND HERBALS.

DO NOT EAT OR DRINK ANYTHING CONTAINING CAFFEINE FOR 24 HOURS BEFORE YOUR TEST (INCLUDING COFFEE, TEA, SODA OR CHOCOLATE).

DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT THE NIGHT BEFORE YOUR EXAM. HOWEVER, DIABETIC PATIENTS MAY EAT A VERY LIGHT BREAKFAST TO MAINTAIN BLOOD SUGAR IF NECESSARY. (EXAMPLES: DRY TOAST AND SMALL JUICE).

TAKE YOUR MEDS WITH SIPS OF WATER DIABETIC PATIENTS: DO NOT TAKE YOUR DIABETIC MEDS IF YOU HAVE NOT EATEN.

WEAR COMFORTABLE SHOES.

Complete the attached questionnaire and bring it with you to your appointment.

If you have any questions regarding your test please call the Cardiopulmonary Dept at 217-245-9541 ext 3379. If you have questions regarding your appointment time or need to reschedule, please call Central Scheduling at 217-479-5696.

The Central Scheduling Department hours are Monday – Friday 7am – 5:30pm.



QUESTIONNAIRE FOR NUCLEAR STRESS TEST

Please complete, prior to your exam, and bring it with you when you come for your test.

Patient Name: _____ **Height:** _____ **Weight:** _____

Reason for doing stress: _____
 _____ Atypical chest pain _____ Palpitations _____ Heart Failure _____ Syncope
 _____ Angina _____ R/O MI _____ Pre-OP _____ Physical

If chest pain, describe: _____
Does it go to the: _____ Back? Is the pain _____ Sharp? Do you get _____ Nauseated?
 _____ Jaw? _____ Dull? _____ Sweaty?
 _____ Arms? _____ Heaviness? _____ Short of breath?
 _____ Shoulders? _____ Pressure?

What are you doing when this occurs? _____ How long does it last? _____
 How long have you had these symptoms? _____

Have you ever had a previous stress test? _____ If yes, when? _____
 Have you ever had a heart attack? _____ If yes, when? _____
 Have you ever had heart surgery? _____ If yes, when and what? _____
 Do you smoke? ___yes ___no If yes, how much? _____ For how long? _____
 If you have quit smoking, when did you quit? _____ How long had you smoked? _____
 Do you consume alcohol? (please circle one).....Never.....SeldomOccasionalFrequent.....
 Do you have any allergies to medicine? ___no ___yes If yes, list: _____

What is your occupation? _____

Do you have any of the following? (If yes, please check)

_____ Diabetes _____ COPD/Asthma _____ High Cholesterol _____ CHF _____ High Blood Pressure

List medications you are currently taking: _____,
 _____,
 _____,

Past Medical History/ Surgical: _____,
 _____,
 _____,

Family History: Answer the following questions for parents. If unknown, put (?)

| | | | | | | |
|------------------------|-------------------------|--------------------|--------------------|----------|-------------------------|-------------------|
| Living or Deceased? | Age now or at death? | Cause of Death? | Heart Problems? | Diabetes | High Blood Pressure? | Cancer? Where? |
|------------------------|-------------------------|--------------------|--------------------|----------|-------------------------|-------------------|

Mother: _____
 Father: _____
 Do you have any brothers and/or sisters? _____ If yes, how many? _____
 Do they have any health problems? ___no ___yes If yes,
 Please Describe: _____



PFT

Appointment Date/Time: _____

Instructions:

Please arrive 15 minutes prior to appointment time.

Allow up to 1 hour for this exam.

This test cannot be done on children under the age of 7.

DO NOT USE INHALERS OR BREATHING MEDICATIONS THE MORNING OF TEST.

PLEASE BRING A LIST OF ALL YOUR CURRENT MEDICATIONS, INCLUDING OVER THE COUNTER AND HERBAL.

Please be sure you bring the physician order with you on the day of your exam or have your physician fax it to: 217-479-5875

If you have any questions regarding your test please call the Cardiopulmonary Dept at 217-245-9541 ext 3379. If you have questions regarding your appointment time or need to reschedule, please call Central Scheduling at 217-479-5696.

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Sleep Study

To prepare for your test;

Avoid Caffeinated Beverages and chocolate after noon the day of your test.

Avoid taking a nap or sleeping late.

Do take all medications, as usual, unless otherwise directed by your physician-please bring a list of all your medications with you.

When you come for your test, bring along something comfortable to sleep in: pajamas, nightgown, jogging suite, etc. Also, feel free to bring your pillow from home.

The Patient Registration Department may contact you to pre-register. Stop at the Ambassadors desks, located at the main registration area, to check in.

If you need to **cancel or reschedule** your exam contact the Central Scheduling Department at 217-479-5696 Monday through Friday, 7 am until 5:30 pm. If you need assistance after hours voicemail is available or contact the Registration Department at 217-479-5547.

Sleep Study Instructions:

1. Please bathe, shampoo and bring clean sleepwear.
2. If you are a man and you shave please do this. If you have facial hair and you do not shave make sure it is clean.
3. No grease in your hair (VO5)
4. No lotion on your legs or chest.
5. If you take a bedtime medicine and have taken the medicine for a long time please take it.
6. Make sure the night of the study you are feeling well, if you do not please call us, at 217-479-5696, ahead of time and we will reschedule the test for a better night.
7. If you have open wounds or sores on your body, please cover them. Due to the electrodes being applied to your head, if you have sores on the top of your head or face, please call today to reschedule your appointment for when those areas are healed.



Sleep Study Information:

A Sleep Study is an overnight test performed in the Cardiopulmonary Department. While you sleep, a continuous recording is made of brain activity, EKG, muscle tension, breathing, respiratory effort, oxygen levels and you will be observed by a video camera (this is not taped).

Electrodes are applied to your scalp, legs, and face and then secured with electrode cream paste and tape. Stretch belts are placed around your rib cage and abdomen and monitors for nasal and oral airflow are placed.

You will be sleeping in a private room. An intercom allows you to call the technologist for assistance. He/she will be close by at all times throughout the night. Please note that no medications will be given to make you sleep, no needles are used, no hair (facial or head) need be shaved, and you may get up to use the bathroom as often as needed.

If we are able to determine early enough that you have a sleep apnea, we will try CPAP (continuous positive airway pressure) to treat your respiratory disturbances. CPAP consists of a triangular mask connected to a small air compressor by tubing. It provides a gentle and constant pressure acting as a "pneumatic splint" to keep your airway unobstructed.

We are not always able to try CPAP the first night. Often it is difficult to note subtle breathing problems while the test is running, on occasion, breathing problems do not show significantly until it is too late to perform the adequate trial of CPAP, therefore you may need to come back for titration.

This is just a short explanation of your sleep study. Please call 217-245-9541, extension 3379 if you have any questions.

Thank you for choosing Passavant Area Hospital for your healthcare needs.



Patient Sleep Study Questionnaire:

PLEASE ANSWER THE FOLLOWING QUESTIONS AND BRING THIS FORM WITH YOU THE NIGHT OF YOUR SCHEDULED SLEEP STUDY

Name: _____ Date: _____

Is this your first test: ____ Yes ____ No If yes, where? _____

Why are you coming in for a sleep study? _____

Height _____ Weight _____

Has your weight been stable in the past year? ____ Yes ____ No

Heart problem? _____ Lung problems? _____

Do you smoke or have you ever smoked? ____ Yes ____ No Packs per day: _____

How many years? _____ Quit? ____ Yes ____ No When? _____

Have you ever had upper airway surgery? ____ Yes ____ No

Tonsils or Adenoids out? ____ Yes ____ No Diabetes? ____ Yes ____ No

Insulin Dependent? ____ Yes ____ No Indigestion or Reflux? ____ Yes ____ No

Snoring? ____ Yes ____ No Tossing/Turning? ____ Yes ____ No

Night sweats? ____ Yes ____ No Waking Headaches? ____ Yes ____ No

Waking confusion? ____ Yes ____ No Do you take naps? ____ Yes ____ No

Difficulty staying awake while driving? ____ Yes ____ No

Average number of hours of sleep per night _____

How long does it take you to fall asleep? _____

How many nights do you wake up? _____

What type of mattress do you sleep on? _____

How many pillows do you use? _____ Do you Dream ____ Yes ____ No

Concentration problems? ____ Yes ____ No Insomnia? ____ Yes ____ No

What shift do you work? _____ How many caffeinated drinks per day? _____

How many alcoholic beverages? _____

PROBLEMS WITH: Check all that apply

Depression ____ Anxiety attacks ____ Claustrophobia ____

Arthritis ____ Chronic pain ____ Dry mouth ____

Sinus problems ____ Leg/body jerks ____

Comments: _____

List Medications: _____

Use the back of form if more space is needed.