PATIENT INFORMED CONSENT

Patient name: Date of birth:

Practioner name: ◯ Will perform at OHSU Tuality Healthcare.

Other practitioners may assist with the procedure(s) as necessary. The following practitioner(s) will perform the specific significant surgical tasks (if any). **Any unforseen circumstances may require changing the assisting at the time of procedure:**

The physician or practitioner has explained to me, in a way that I understand, the planned procedure or treatment, anticipated benefits, material risks or potential problems that might occur during the procedure or treatment or during recuperation as well as the likelihood of achieving our goals. He/she has also discussed alternative therapies, including no treatment, as well as the anticipated benefits and risks associated with those alternative treatments. The following are among the risks or concerns discussed.

There may be alternative procedure(s), treatments or therapies which may include, but are not limited to: No treatment at all, Cardiac CT, Cardiac MRI, Cardiac Catheterization.

The risks of the procedure(s) may include, but are not limited to: Chest discomfort, shortness of breath, hypertension or hypotension, supraventricular arrhythmias (up to 6%), ventricular arrhythmias (up to 25%), heart attack or death (0.04%). Additionally, for vasodilator agents: headache, flushing, wheezing, chest pressure, nausea.

Select procedure to be performed:

- ◯ Treadmill Exercise Stress Test.
- ◯ Exercise Stress Echocardiogram.
- ◯ Dobutamine Stress Echocardiogram.
- ◯ Vasodilator Myocardial Perfusion Echocardiogram using Ragadenoson.
- ◯ Nuclear Medicine Exercise Stress Test using:
  - ◯ Ragadenoson.
  - ◯ Adenosine.
  - ◯ Dobutamine.
  - ◯ Cardiopulmonary Exercise Stress Test.

Please check if appropriate:

- ◯ I understand that a vendor's company representative may be present during my procedure / operation to serve as a resource for products used during my procedure(s).
- ◯ A blood transfusion may be required during or after the procedure(s) and I consent to receive blood or blood products as deemed necessary and appropriate by my practioner.
- ◯ I refuse to receive blood products even if it results in death or serious disability.

Please check one:

- ◯ My practitioner has explained my procedure(s), including the nature and purpose, potential benefits, material risks, including those related to recuperation and the likelihood of achieving care treatment, goal(s), and asked if I want a more detailed explanation, but I am satisfied with the explanation and do not want any more information. I give my permission and consent to the procedure(s).
- ◯ I requested and received in substantial detail, further explanation of the procedure(s), other alternative procedure(s) or methods of treatment and information about the material risks and benefits of the procedure(s) or treatment. I give my permission and consent of the procedure(s).

Patient / authorized representative signature: Witness: Date:

I explained the above procedure(s) to the patient or authorized representative.

Practitioner's signature: Date:

Print name: Time: