GWINNETT CLINIC CARDIOLOGY
TEST LOCATION:
475 PHILIP BLVD, SUITE 200
LAWRENCEVILLE, GA 30046
P: (678) 226-6200 FAX: (678) 240-2152

INSTRUCTIONS FOR EXERCISE STRESS TEST

1. If you have *not* received a confirmation call 24-48 hours prior to your scheduled appointment, please call 678-226-6200 to confirm. If you are not able to reach a representative, please call 770-765-1101 to confirm the appointment. Otherwise, we will assume you are not coming and cancel the test.
2. This test is done in the Lawrenceville office on the 2nd floor. **Please check-in at the 2nd Floor Radiology Desk.**
3. Please bathe the morning of your test. Do not apply lotion, oil, or perfume to your chest or abdomen, because the EKG leads will not adhere properly. You may use antiperspirant/deodorant – they do not interfere with the test.
4. Please DO NOT smoke cigarettes or use any tobacco products on the day of your test.
5. Do not eat or drink ***4 hours before*** the test, and ***do not have any form of caffeine 24 hours prior***. This includes coffee, tea, soda, and/or chocolate. Decaffeinated products still contain trace amounts of caffeine, so avoid these as well.
6. You will be on a treadmill (unless otherwise indicated by your doctor), so please wear appropriate clothing.
   - Wear comfortable exercise clothes and sneakers/exercise shoes (**NO** flip flops / sandals or your test will be rescheduled). Be prepared to walk/run on the treadmill.
7. **Allow up to 2 hours for the test.** Plan to be in the office about an hour before your scheduled appointment time.
8. You may bring any medications, food, or drink with you to take immediately after your test.
   - Please bring a fatty non-caffeinated snack with you (example: cheese or nuts).
9. If you are diabetic, you should check with your physician concerning fasting and taking insulin on the day of your test.
10. Please bring a current list of medications you are taking, as well as your test order form.

Instructions can be found online: www.gwinnettclinic.com/HeartTest

*** PLEASE SEE BACKSIDE FOR INSTRUCTIONS REGARDING ANY CURRENT MEDICATIONS YOU MAY BE TAKING***

If you do not see your medication on this list, please double check with your Physician or Medical Assistant whether or not you should take your medications on the day of your test.

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MEDICATIONS THAT CANNOT BE TAKEN BEFORE TEST

Adalat (Nifedipine)

Atenolol (Tenormin)

Blocadren (Timolo Maleate)

Calan (Verapamil)

Cardene (Nicardipine)

Cardizem (Diltiazem)

Corgard (Nadolol)

Edecrin (Etacrynic Acid)

Esldrix (HCTZ)

Inderal (Propranolol)

Isoptin (Verapamil)

Isordil (Isosorbide dinitrate)

Istalol (Timolol)

Lanoxin (Digoxin)

Lasix (Furosemide)

Lopressor (Metoprolol)

Microzide (HCTZ)

Nitroglycerin in any form

Minitran (Nitroglycerin Patches)

Nitrodisc (Nitroglycerin)

Nitro-Dur (Nitroglycerin)

Nitroglycerin Ointment

Nitrostat

Normodyne (Labetalol)

Norvasc (Amlodipine)

Procardia (Nifedipine)

Sectral (Acebutolol)

Toprol (Metoprolol)

Trandate (Labetalol)

Transderm Nitro

Visken (Pindolol)

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PATIENT CONFIRMATION OF RECEIPT
EXERCISE STRESS TEST INSTRUCTIONS

I, ___________________________, have read and understand these instructions as they have been given to me. I also understand that if I fail to comply with any of the aforementioned instructions, I will have to reschedule my test for another day, as it is available to me. I have been supplied a copy of the instructions for my records as well.

____   ________________________________
PATIENT/REPRESENTATIVE SIGNATURE   **RELATIONSHIP (IF REPRESENTATIVE)**

____   ________________________________
PRINT NAME (PATIENT/REPRESENTATIVE)   **DATE**

______________________________   ___________________________   ___________________
WITNESS SIGNATURE   **PRINT NAME**   **DATE**

Please **initial** below.

I have no questions ___________________   My questions have been answered ___________________

I have decided *not* to have this test. My provider has explained to me the possible risks of NOT having this examination.

_____________________________________   _______________________________________
Patient/Representative Signature   **Patient/Representative Print Name**

_____________________________________   _______________________________________
Witness Signature   **Witness Print Name**

Comments/Reason for decline: