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DEPARTMENT OF NUCLEAR MEDICINE

Patient's/legal representative's informed consent to myocardial perfusion scintigraphy (SPECT)

Patient – name and surname:	Birth registration number (insurance number):
Date of birth: (if no birth certificate number exists)	Health insurance company code:
Patient's permanent address: (or other address)	
Name of legal representative (guardian):	Birth Registration No.

Name of procedure

Myocardial perfusion scintigraphy (SPECT)

Purpose of the procedure

The objective of the examination is to evaluate blood perfusion of the cardiac muscle and performance of the heart ventricles.

Nature of the procedure

This is a diagnostic method during which a substance labelled with a radioactive isotope with a short decay half-life is intravenously injected into patient's body. Typically, the radiopharmaceutical is administered during stress (physical exercise), although examination at rest only is performed in some patients based on the doctor's decision. The examination during physical exercise consists in bicycle ergometry (bicycle test). If you cannot undergo the bicycle test or if its result would not be sufficient, then the pharmacological type of stress is an alternative: this is a method in which higher perfusion of the heart muscle is achieved by administration of a suitable drug (dipyridamole or dobutamine). This is followed by data scanning using a scintillation camera (SPECT); additional examination at rest is largely required.

Expected benefit from the procedure

Evaluation of perfusion of the heart muscle and performance of the heart ventricles is important for the diagnostics of the ischemic heart disease (IHD) and assessment of its prognosis (decision as to whether the patient should undergo coronary intervention, surgery or medication). This examination also helps assess the viability of the various regions of the heart muscle.

Alternatives to the procedure

No alternative exists to this examination.

Potential risks of the procedure

Radiation stress associated with this examination is similar to that in the majority of radiodiagnostic procedures.

Consequences of the procedure

No characteristic adverse consequences of the procedure exist provided that no complications have developed during the stress test.

Information on discharge after administration of the radiopharmaceutical

You need not limit your contact with your family due to the radiation stress (it is advisable, though, to wait for a few hours before you get in contact with children and/or pregnant women). If the patient is incontinent, vomiting, etc., the dirty diapers or other materials must be stored in a plastic bag outside the residential areas (e.g. in a cellar or garage) for 48 hours and then either disposed of or washed.

Consent:

Note: Circle your answer

Are you pregnant?	YES	NO
Are you breastfeeding?	YES	NO

I have been clearly informed about existing alternatives available to me at the University Hospital Olomouc.	YES	NO
I have been informed about the potential limitations to my usual way of living and to my working ability after the medical procedure and about potential changes in my medical fitness in the event of potential or expected change in my health.	YES	NO
I have been informed about the treatment regimen and appropriate preventive measures as well as about the follow-up medical procedures.	YES	NO
I have understood all of the explanations and information that were provided and explained to me by a healthcare professional. I had the opportunity to ask additional questions and these were answered to my satisfaction.	YES	NO

After obtaining the aforementioned information I declare that:		
- I agree to the medical care and procedure proposed. I also agree to any additional interventions that may be immediately required to save my life or health in the event of any unexpected complications	YES	NO
- I did not withhold any facts about my medical condition that are known to me and which might have an adverse impact on my treatment or endanger people around me, particularly by transmission of an infectious disease	YES	NO
- I give my consent to the collection of my biological material (blood, urine…) for the appropriate analyses, particularly in order to rule out the presence of any infectious disease.	YES	NO
- I agree to the presence of students and/or interns during medical services provision	YES	NO
- I agree to it that students and interns may view my medical documentation, but only to the necessary extent and based on permission granted to them by an authorised healthcare professional	YES	NO

Date	Time	**Signature of the patient** or his/her legal representative (guardian)

Name and surname of the authorised healthcare professional who informed the patient about the preparatory activities and the procedure itself	**Signature** of the authorised healthcare professional who informed the patient about the preparatory activities and the procedure itself

Name and surname of the physician who informed the patient about the indications and contraindications of the procedure	**Signature** of the physician who informed the patient about the indications and contraindications of the procedure	Date	Time

If the patient is unable to sign himself/herself, explain the reasons of this:			
Describe how the patient expressed his/her will:			
Name and surname of the healthcare professional/a witness who was present:	**Signature of the healthcare professional/a witness who was present:**	**Date**	**Time**