# טופס הסכמה: בדיקת אקו לב במאמץ בהשראת דוביוטמין

# Dobutamine Stress Echo (DSE)

The purpose of the test is to examine the contraction of the heart during effort by patients who are not able to make the effort to walk, in order to evaluate the blood supply to the heart muscle. With the help of the test it is possible to foretell, with high probability, the existence of significant narrowing of one or more of the coronary arteries supplying blood to the heart muscle and to evaluate the function of the valves. Evaluation of the heart function is done by ultrasound waves. During the test an intravenous infusion is given with the medication called dobutamine which causes acceleration of the pulse and increases the heart contractions, as an expression of effort. The effect of the medication wears off after a few minutes after its cessation. The test is carried out lying on the left side and the medication infusion lasts 15 minutes.

Name of Patient: _____ _____ _____ _____

Last Name | First Name | Father's Name | ID No.

I hereby declare and confirm that I received a detailed verbal explanation from:

Dr. _____ _____

Last Name | First Name

on the process of the dobutamine echo test (hereafter: "the main test").

I hereby declare and confirm that it has been explained to me that in the course of the test I will feel strong and accelerated heart palpitations. Also the side effects of the test have been described to me, including: chest pain, shortness of breath, headache, dizziness; there may also be disturbances in the heart rhythm and blood pressure changes, urine retention, dryness of the mouth or increased pressure in the eyes.

Very rare complications of the test have also been explained to me, including damage to the heart muscle or severe rhythm disturbances and even death.

I know and agree that the main test and all other procedures will be carried out by whoever is designated to do so, and it has not been promised to me that they will be performed wholly or in part by a certain person, and only according to the institutional procedures and directives of the hospital with the standard degree of responsibility and according to the law.

_____ _____ _____

Date | Time | Patient's Signature

_____ _____

Name of Guardian (Relationship) | Guardian's Signature (for incompetent, minor or mentally ill patients)

I hereby confirm that I provided the patient / the patient's guardian with a detailed verbal explanation of all the above mentioned, as required, and that he/she signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

_____ _____ _____

Name of Physician | Physician's Signature | License No.

| Date | Time | Patient's Signature |
|---|---|---|

| Name of Guardian (Relationship) | Guardian's Signature (for incompetent, minor or mentally ill patients) |
|---|---|

I hereby confirm that I provided the patient / the patient's guardian* with a detailed verbal explanation of all the abovementioned, as required, and that he/she signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

| Name of Physician | Physician's Signature | License No. |
|---|---|---|

* Cross out irrelevant option.