



CEDARS-SINAI®

S. MARK TAPER FOUNDATION  
IMAGING CENTER

PATIENT I.D.

**REST MIBI / REST THALLIUM / CARDIAC FDG PET OR  
RESTING WALL MOTION / FIRST PASS WITH BONE SCAN**

Reason for test: (circle)

- |                  |            |                |                      |                  |
|------------------|------------|----------------|----------------------|------------------|
| Acute Chest Pain | Lung CA    | Endometrial CA | Hodgkin's Lymphoma   | Mesothelioma     |
| CHF              | Breast CA  | Prostate CA    | Non-Hodgkin's Lymph. | Multiple Myeloma |
| Cardiomyopathy   | Ovarian CA | Pancreatic CA  | Lymphoma             | CA-other         |
| Valve disease    | Bladder CA | Osteosarcoma   | Leukemia             | Other            |
- Pre-heart transplant

PLEASE CHECK THE FOLLOWING

- |                                 |   |  |            |
|---------------------------------|---|--|------------|
| History of MI                   | <input type="checkbox"/> Yes              | <input type="checkbox"/> No                        | date _____ |
| History of Angiography          | <input type="checkbox"/> Yes              | <input type="checkbox"/> No                        | date _____ |
| History of PTCA                 | <input type="checkbox"/> Yes              | <input type="checkbox"/> No                        | date _____ |
| History of Cardiac Surgery      | <input type="checkbox"/> Yes              | <input type="checkbox"/> No                        | date _____ |
| <input type="checkbox"/> Bypass | <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Aortic Valve Mitral Valve |            |

RISK FACTORS

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Hypertension                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Insulin   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Cholesterol                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Smoking   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Family history of coronary artery disease (CAD) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

SYMPTOMS

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| History of chest pain in past 12 months?    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does it occur in center of chest?           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does it go away with rest or nitroglycerin? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Experience shortness of breath?             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Admitted for chest pain or equivalent       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Brief history: \_\_\_\_\_

ACUTE USE OF SESTAMBI (A form of stress test, a Sestambi scan is a cardiac study that measures blood supply to the heart) (ER OR NON-ER):

Primary MD or Cardiologist (first and last name; city or FAX # if non-Cedars-Sinai):

Chest pain: Intermittent or Constant (circle one)

Duration of chest pain: # \_\_\_\_\_ Weeks Days Hours Minutes Seconds (circle one, fill in #)

Chest pain during SESTAMBI injection?  Yes  No

If no, how long before sestambi injection did chest pain resolve:

# \_\_\_\_\_ Weeks Days Hours Minutes Seconds (circle one, fill in #)

Did the patient take / receive nitroglycerin before sestambi injection?  Yes  No

NAME OF PATIENT (please print)		SIGNATURE OF PATIENT		DATE	TIME
NAME OF STAFF (please print)		TITLE	SIGNATURE OF STAFF	DATE	TIME