



Disability Testing Information Packet

Requirements for testing

1. Ability and willingness to provide an excellent effort on both exercise tests.
2. Arrange transportation to and from the appointment.
 - We will be unable to provide testing services if you drive yourself.
3. Complete and return the following:
 - Cardiopulmonary Exercise Testing Referral
 - Cardiovascular Risk Stratification
 - Informed Consent
 - Medication List
 - Authorization to Release Records

Please email or fax paperwork to:
info@workwellfoundation.org
(209) 599-4047 - fax



Cardiopulmonary Exercise Testing Referral

Please complete and return to Workwell Foundation
 Fax: 209-599-4047
 Email: info@workwellfoundation.org

Patient Information:

Patient Name	
Primary Diagnosis (include ICD-10 code)	
Other Diagnoses (include ICD-10 codes)	
Contraindications	
Comments	

Physician Information:

Physician Name	
Office Address	
City/State/Zip	
Office Phone/Fax	
Physician Email Address	

Physician Signature

Date

Cardiovascular Risk Stratification

Name			Date
DOB	Age	Height	Weight
Phone			
Address			
Email			
Diagnosis			

Yes	No	Do you have a history of cardiovascular or pulmonary disease?	
Yes	No	Do you have a family history of cardiovascular disease? <ul style="list-style-type: none"> ▪ Heart attack ▪ Coronary revascularization ▪ Sudden death <ul style="list-style-type: none"> ○ Before 55 yrs of age in father or 1st degree male relative ○ Before 65 yrs of age in mother or 1st degree female relative 	
Yes	No	Do you smoke?	
Yes	No	Do you have high blood pressure or take medication to regulate blood pressure? <ul style="list-style-type: none"> ▪ Systolic ≥ 140 mmHg or diastolic ≥ 90 mmHg 	
Yes	No	Do you have high cholesterol or take medication to regulate cholesterol? <ul style="list-style-type: none"> ▪ Total serum cholesterol of >200mg/dL 	
Yes	No	Do you have impaired fasting glucose or take medication to regulate blood glucose? <ul style="list-style-type: none"> ▪ Fasting blood glucose of ≥ 100mg/dL 	
Yes	No	Are you sedentary? <ul style="list-style-type: none"> ▪ Not participating in a regular exercise program for 30 minutes per day, 3 days per week. 	
Yes	No	Are you obese? <ul style="list-style-type: none"> ▪ Body Mass Index ≥ 30kg/m² or waist girth of > 100cm 	
Yes	No	Are you at an age-related risk for cardiovascular disease? <ul style="list-style-type: none"> ▪ Men ≥ 45 years of age; Women ≥ 55 years of age 	
Participant signature			Date

Informed Consent

Cardiopulmonary Exercise Testing (CPET)

You agree to participate in a series of tests that will examine the involvement of various bodily systems in response to a standardized physical stressor. You will be asked to complete two exercise tests over a two day period. You will also be asked to complete questionnaires during a seven day follow-up period after the second exercise test.

The exercise tests are comparable to approximately 8-12 minutes of strenuous physical activity. You may experience a number of adverse responses during the tests including pain, musculoskeletal damage, cardiovascular complications, and in rare instances, heart attack, stroke or death. There may also be a delayed recovery period following the exercise tests. It is expected that this discomfort may be significant and include pain, muscle and joint soreness, lightheadedness and prolonged fatigue. Each appointment will last approximately 90 minutes. It is expected that the data gained from this testing will provide important information about the biological changes that occur when persons with fatigue-related illnesses experience physical stress. Workwell Foundation is not financially responsible for any related medical or travel expenses.

Any information that is obtained in connection with this testing will remain confidential and will not be disclosed without your permission. The information will be provided only to you and your authorized recipients.

You are solely responsible for arranging transportation to and from the testing site. You will be asked to bring someone to accompany and drive you to and from the office because you may need assistance. This is especially true for the post-test malaise/fatigue you are likely to experience. We will be unable to provide you with testing services if you choose to drive yourself.

Signature

Date

Electroencephalogram (EEG)

You agree to participate in electroencephalography testing. The procedure will occur post-exercise test 2. We hope to learn what the effects of physical stress have on cognitive functioning. If you choose to participate, data obtained may be shared with WAVi for analysis. EEG provides a cognitive stress that may trigger post exertional symptoms. There may also be an extended recovery period following the EEG.

Any information that is obtained in connection with this testing will remain confidential and will not be disclosed without your permission. The information will be provided only to you and your authorized recipients.

Your signature below indicates that you have read and understand the information provided above, that you willingly agree to participate, that you may withdraw your consent and/or discontinue participation at any time, that you will receive a copy of this form upon request, and that you are not waiving any legal claims, rights or remedies.

Signature

Date

Authorization to Release Records

Patient's Name: _____ Date of Birth: _____

I request and authorize: **Workwell Foundation, Ripon CA 95366** to release my confidential testing information to:

Release To:
(Mailing Address or Email Address):

We prefer to release electronic copies to reduce the impact on the environment. Please provide an email address or fax number in lieu of physical mailing addresses if possible.

A fee of \$10/report will apply for mailing hard copies

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

All records for dates beginning _____ / _____ / _____
and ending on _____ / _____ / _____

This information cannot be given to any other individual or agency without the patient's authorization.

This authorization expires _____ / _____ / _____. If no date is specified, this Authorization expires one year from the date specified below.

PRINTED NAME: _____

PATIENT SIGNATURE: _____

DATE: _____ / _____ / _____

Cardiopulmonary Exercise Testing

Preparation & Recovery Tips

Before the Test:

- Plan to have someone drive you to and from the testing facility. We will be unable to provide you with testing services if you drive yourself.
- Wear comfortable clothing to exercise in such as a short sleeve t-shirt with a loose neck, sweat pants and comfortable shoes.
- Women should wear a sports bra or a bra with no metal wire. If an underwire bra is worn, you may be asked to remove it.
- Do not use oily products such as lotion or vapor rub.
- The last meal before the test should be light and eaten at least three hours prior to the exercise test.
- Drink plenty of water starting the day before testing to make sure you are well hydrated.
- Carbonated and caffeinated beverages (i.e., Pepsi, Coke), alcohol, coffee and tea should be avoided.
- Avoid exercise for at least 24 hours prior to testing.
- Bring a wheelchair or cane for assistance if needed.

After the Test:

- Drink plenty of fluids. Avoid caffeinated (coffee and tea) and alcoholic beverages.
- Stretch muscles frequently. If you are too tired to stretch by yourself have someone else help (assisted stretching).
- Take a warm shower or bath and stretch when the muscles are warm and flexible.
- The use of intravenous (IV) saline can facilitate recovery. Administration should take place under the supervision of a physician and/or qualified personnel.
- Plan to rest until recovered.

Price Listing†

Cardiopulmonary exercise test-retest protocol:

The CPET protocol consists of two maximal cardiopulmonary exercise tests separated by 24 hours. This 2-day design is used to elicit a fatigued state while assessing the responses of the metabolic, cardiovascular and pulmonary systems.

Measurements include:

- Resting and stress electrocardiogram (ECG)
- Cardiopulmonary analysis of graded bicycle test to maximal exertion
- Determination of the ventilatory/anaerobic threshold (V/AT) and corresponding heart rate
- Determination of peak aerobic capacity (VO₂ max)

Electroencephalogram protocol:

The EEG protocol consists of a brainscan after the second CPET to evaluate cognitive function. EEG provides a noninvasive objective measure of brain electrical activity at very high temporal resolution, allowing millisecond-level recordings of brain wave frequency and amplitude via electrodes on the scalp

Testing fees:

\$2,250	CPET low/moderate risk patient
\$2,650	CPET high risk patient requiring medical supervision
\$750	EEG

In order to complete the entire testing protocol, the patient must be available over a 2-day period. A report with personalized interpretation of the CPET results will be provided. Upon request, reports can be also be provided to physicians and/or legal counsel.

Payment is required in full prior to scheduling the appointment. In the case of a cancellation, there is **10% cancellation fee** that is **nonrefundable**. If traveling by air, travel insurance is highly recommended.

*Patients considered high risk for cardiovascular disease require physician supervision

† Fees are subject to change