



Student Athlete Echocardiogram (ECHO) and Electrocardiogram (EKG) Screening

Part 1. Student Information (to be completed by student or parent)

Student's Name (First & Last): _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (work) _____ (cell) _____

Gender: Male Female Age: _____ School: _____ Sport(s): _____

Height: _____ Weight: _____

In case of emergency, contact:

Name of Parent/Guardian: _____

Relationship to Student: _____ Phone: _____

Part 2. Informed Consent (to be completed by student and parent)

Louisiana Pediatric Cardiology Foundation (LPCF), in conjunction with Pediatric Cardiology Associates (PCA) offers screening as a part of our commitment to serving the preventive health needs of needs of our community. This form is meant to inform the screening participant about the screening and to document the participant's consent to the screening. The form is meant to inform the participant of the importance of taking personal responsibility for healthcare needs and asks for a personal commitment from the participant to obtain appropriate follow-up care and treatment in the event the screening is abnormal. In order to participate and be screened through LPCF's **"Save-A-Heart"** Screenings Program, every participant must read and sign this Notice, Informed Consent and Release.

ABOUT THE SCREENING: LPCF screens young adults for a genetic heart condition called hypertrophic cardiomyopathy (HCM). This condition, which causes a thickening of the heart wall, typically does not present any symptoms and can lead to the obstruction of blood flow and an erratic heart beat. It is the leading cause of sudden cardiac death in young people.

Sudden cardiac death (also called sudden arrest) is death resulting from an abrupt loss of heart function (cardiac arrest). The victim may or may not have diagnosed heart disease. The time and mode of death are unexpected. It occurs within minutes after symptoms appear. When sudden death occurs in young adults, other heart abnormalities are more likely causes. Adrenaline release during intense physical or athletic activity often acts as a trigger for sudden death when these abnormalities are present.

An echocardiogram, also referred to as an "ECHO", is a technique that sends sound waves (like sonar) into the chest to rebound from the heart's walls and valves. The recorded waves show the shape, texture, and movement of the valves on an echocardiogram. They also show the size of the heart chambers and how well they are working.

An electrocardiogram, also called an “EKG”, is a test that measures the electrical activity of the heartbeat. With each beat, an electrical impulse (or “wave”) travels through the heart. This wave causes the muscle to squeeze and pump blood from the heart. An EKG gives two major kinds of information. First, by measuring time intervals on the EKG, a doctor can determine how long the electrical wave takes to pass through the heart. Finding out how long a wave takes to travel from one part of the heart to the next shows if the electrical activity is normal or slow, fast or irregular. Second, by measuring the amount of electrical activity passing through the heart muscle, a cardiologist may be able to find out if the parts of the heart are too large or are overworked.

RISKS: This screening does not hurt and is non-invasive. No needles or sedation is used. However, should the participant experience chest pain, difficulty breathing, discomfort radiating into the neck or arm, or discomfort combined with lightheadedness, sweating, fainting or nausea, the participant should seek prompt medical attention.

PARTICIPATION: By voluntarily participating in this screen program and by receiving a screening I recognize, understand, and accept all risks and responsibilities associated with and resulting from it. This screening program will only screen for abnormalities in the heart using the electrocardiogram and echocardiogram, and does not constitute a complete medical examination or diagnosis. Test results do not represent or imply that I MAY or MAY NOT be at risk for sudden cardiac death. Although an echocardiogram cannot definitely diagnose hypertrophic cardiomyopathy, it may indicate levels of probability of having or not having hypertrophic cardiomyopathy.

CONFIDENTIALITY: As part of this screening, I agree to allow physicians, medical personnel, and staff of both LPCF/PCA to have access to my medical records from this screening. I allow LPCF/PCA and its physicians, medical personnel, and staff to contact me in regards to my participation in this screening program. I also authorize LPCF/PCA to use this information, including the results of this screening test for statistical evaluation; however, I understand that I will not be individually identified in any recognizable way. The results of the screen will be released to me, and the confidentiality of my medical records will be maintained.

TEST RESULT NOTIFICATION: A pediatric cardiologist at PCA will read every test the week following the screens. LPCF/PCA will send the results to the primary care physician indicated on the history form. LPCF/PCA will contact the parent of the student directly if there are any results other than normal. Finally, LPCF/PCA will mail a letter indicating a normal test to the remaining students’ parents. Please allow 2-3 weeks to receive the normal letters.

I recognize and acknowledge that I am personally responsible for taking appropriate follow-up action upon receipt of test results. I understand and acknowledge that it is my responsibility to decide whether to take this action and pursue medically indicated care and treatment. It is my responsibility to discuss the results of the screening with my primary care physician and, if indicated, begin a medically approved modification program based on the findings and recommendations of my primary care physician.

If I do not have a primary care physician, I understand that I am strongly encouraged to engage the services of a primary care physician to review the results of an abnormal screen and to determine my follow-up healthcare needs. The physicians of PCA are not primary care physicians and, therefore assume no responsibility or liability relative to my follow-up care. Should I receive notice of an abnormal screen, I understand that any delay on my part to follow-up with my primary care physician in a timely manner could result in adverse health consequences.

I hereby authorize PCA to release the results of my screening test to the primary care physician indicated on the history form contained in Part 3 below. This authorization may be revoked at any time by submitting a written notice to **PCA, 7777 Hennessy Blvd., Suite 103, Baton Rouge, Louisiana 70808**. The release of my Protected Health Information by PCA shall at all times be governed by PCA’s Notice of Privacy Practices, which I have received a copy of as Part 4 of this form.

CONSENT, AGREEMENT, AND WAIVER: I have read, understand, and accept this Notice, informed Consent and Release. I have had the opportunity to ask questions and my questions have been answered in a satisfactory manner. I have been informed as to the purpose of this screening and I freely consent to be a participant in the screen. I understand and assume all risks associated with my participation in this screen program. **I understand that the screening program will only screen for abnormalities in my heart for genetic heart condition, and does not constitute a complete medical**

exam or diagnosis. I understand abnormal test results do not represent or imply that I DO or DO NOT have a heart condition. By signing this consent and waiver, I hereby agree to waive any legal claim against LPCF and their directors, officers, employees and agents (collectively "Indemnified Parties"), and I further agree to indemnify and hold harmless the Indemnified Parties from and against any claim, loss, damage, cost, expense (including reasonable attorney's fees) or liability arising out of or related to the failure of the screening and/or the corresponding interpretation of the results to detect heart disease, abnormalities or any other illness.

For a diagnosis of a medical problem, I acknowledge that I must see a physician for a complete medical examination. I understand that I am responsible for my own health. I understand that I am responsible for all follow-up examinations to check abnormalities found during this screening. I am financially responsible for the cost of any follow-up care, treatment, and/or procedures whether or not covered by my insurance. I received a copy of this Notice, Informed Consent and Release prior to treatment by Pediatric Cardiology Associates. I understand and agree to the use of information from medical records in accordance with the limitations set forth in this consent form and the Notice of Privacy Practices attached as Part 4 of this form.

Having read this Notice, Informed Consent and Release, and in consideration of LPCF accepting me for participation in this screen program, I, for myself and for anyone on whose behalf I am entitled to act, release LPCF/PCA, its physicians, medical personnel, agents, and sponsors from all claims of any kind arising out of my participation in this screening program.

Signature of Student/Participant Date

Signature of Parent/Guardian Date

Part 3. Medical History (to be completed by student or parent)



**Louisiana
Pediatric
Cardiology
Foundation**

Explain “yes” answers below. Circle questions you do not know answers to.

Student’s Name (First & Last): _____ Date of Birth: _____

Name of Primary Care Physician: _____ Phone #: _____

1. Has it been more than two years since you had a physical exam that included a blood pressure reading and listening to your heart?	YES	NO
2. Have your parents or has a physician ever told you that you have a hear murmur?	YES	NO
3. Has a physician ever suggested that you not participate in athletic competition?	YES	NO
4. Have you had a chest pain/pressure, dizziness, or racing or “skipped beats” at rest or with exercise?	YES	NO
5. Have you ever fainted or passed out during exercise or after having been startled?	YES	NO
6. Have you ever fainted or passed out after exercise?	YES	NO
7. Have you ever been told that you have high blood pressure, high cholesterol, or diabetes?	YES	NO
8. Have you ever been diagnosed with unexplained seizures or exercise induced asthma?	YES	NO
9. Do you use or have you ever used cocaine or anabolic steroids, or do you smoke?	YES	NO
10. Has anyone in your family had sudden, unexpected death before 45?	YES	NO
11. Has anyone in your immediate family had unexplained fainting or seizures?	YES	NO
12. Has a physician diagnosed anyone in your family with an abnormally thickened heart, weakened heart, or Marfan syndrome?	YES	NO

If the answer to any of the above questions is “yes”, please give more details: _____

Answered by:

Signature of Student: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

PART 4: Notice of Privacy Practices (PAGES 5-8 FOR YOU TO KEEP FOR YOUR RECORDS)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice of Privacy Practices is adopted to ensure that **PEDIATRIC CARDIOLOGY ASSOCIATES OF LOUISIANA, INC. ("PCA")** fully complies with all federal and state privacy protection laws and regulations, in particular, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). PCA is required by law to provide its patients with a copy of this Notice of Privacy Practices. This Notice of Privacy Practices shall become effective as of May 1, 2013, and shall remain in effect until it is either amended or cancelled.

If you have any questions or comments concerning this notice, you should contact the Chief Privacy Officer, c/o PCA, 7777 Hennessy Blvd., Suite 103, Baton Rouge, Louisiana 70808, by mail or by telephone at 225-767-6700. For the purposes of this notice, **"HHS"** shall mean the United States Department of Health and Human Services and **"Health Information", "Protected Health Information" or "PHI"**, shall mean, certain Individually Identifiable Health Information, as defined in 45 C.F.R. § 164.501 of the Privacy Standards.

Information Collected. In the ordinary course of business, PCA may receive certain personal information about a patient and we will create a record of the care and/or services provided to the patient by PCA. Some of the information also may be provided to us by other individuals or organizations that are part of the patient's "circle of care", such as a patient's referring physician, other doctors, health plan, family members, hospitals or other health care providers.

How PCA May Use or Disclose a Patient's PHI. PCA collects PHI from the patient and stores it in an account file. This is the patient's medical record. The medical record is the property of PCA, but the information in the medical record belongs to the patient. In the event that PCA is sold or merges with another organization, the patient's PHI will become the property of the new owner. PCA protects the privacy of the patient's PHI. It is the policy of PCA that PHI may not be used or disclosed unless it meets one of the following conditions:

Treatment. PHI may be transmitted to various departments within our organization, the patient's referring physician and other entities associated or involved in the patient's treatment. This information may also be disclosed to the patient's physicians in association with the patient's treatment including but not limited to any physical therapy or home health entities.

Payment. PCA will collect billing information from the patient such as the patient's present address, social security number, date of birth, health insurance carrier, policy number and any other related billing information. PCA may disclose to the patient's health insurance provider, Medicare, Medicaid, or other payor of health care claims the minimum amount necessary of the patient's PHI in order to process the patient's health insurance claim.

Health Care Operations. PCA may disclose the patient's healthcare information to physicians, medical assistants, nurses, nurse practitioners, physician assistants, radiology personnel, MRI technologists, billing clerks, administrative staff and other employees involved in the patient's healthcare treatment.

Authorization. PCA may disclose the patient's healthcare information if the patient, who is the subject of the information, through a written authorization, has authorized the use or disclosure of the information. This authorization may be revoked by the patient providing PCA with a written revocation of said authorization. Without the patient's authorization, PCA may not disclose the patient's psychotherapy notes. PCA may also not use or disclose the patient's PHI for marketing and may not sell the patient's PHI. PCA may disclose the patient's healthcare information if patient, who is the subject of the information, does not object to the disclosure of their PHI to persons involved in the health care of the individual or for facility directory purposes.

Notification and communication with family. We may disclose the patient's PHI to notify or assist in notifying a family member, the patient's personal representative or another person responsible for the patient's care about the patient's location, their general condition, or in the event of the patient's death. If the patient is able and available to agree or object, we will give the patient the opportunity to object prior to making this notification. If the patient is unable or unavailable to agree or object, our health professionals will use their best judgment in communication with the patient's family and others. It is the policy of PCA that a voice mail or answering machine message may be left at a patient's home or other number the patient provides to PCA regarding appointments, billing or payment issues, or other PHI, related to treatment, payment or health care operations.

As Required by Law. It is the policy of PCA that we may use and disclose a patient's PHI as required by applicable law including to public health authorities for public safety purposes such as preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. We may disclose a patient's PHI as required by law to health agencies during the course of audits, investigations, inspections, licensure, and in the course of any administrative or judicial proceeding and to law enforcement officials for national security, identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and/or for other law enforcement purposes. We may also disclose a patient's PHI to coroners, medical examiners and funeral directors and to organizations involved in procuring, banking or transplanting organs and tissues. We may disclose a patient's PHI to researchers conducting research that has been approved by an Institutional Review Board or PCA's Board of Directors. We may disclose a patient's PHI as necessary to comply with worker's compensation laws. It is the policy of PCA that oversight agencies such as the Office for Civil Rights of the Department of Health and Human Services be given full support and cooperation in their efforts to ensure the protection of PHI within this organization. It is also the policy of PCA that all personnel cooperate fully with all privacy compliance review and investigations.

Fundraising. We may use certain information (name, address, telephone number or email information, age, date of birth, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for fundraising purposes and you will have the right to opt out of receiving such communications with each solicitation. The money raised will be used to expand and improve the services and programs we provide the community. You are free to opt out of fundraising solicitation, and your decision will have no impact on your treatment or payment for services at PCA.

Notice of Privacy Practices and Breach Notification. It is the policy of PCA that privacy practices must be published and that all uses and disclosures of PHI are done in accordance with PCA's privacy policy. PCA is required by law to abide by the terms of its Notice of Privacy Practices. It is the policy of PCA that privacy protections extend to information concerning deceased individuals. If there is a breach (an inappropriate use or disclosure of the patient's PHI that the law requires to be reported) PCA must notify the patient of said breach.

Restriction Requests. The patient has the right to request restrictions on certain uses and disclosures of their PHI. The patient may do so by completing PCA's form entitled "Restrictions". PCA is not required to agree to the restriction that the patient requests. If a particular restriction is agreed to, PCA is bound by that restriction. If a patient pays for a specific health product or service out of pocket, the patient has the right to request that PCA not disclose their information to their insurer. Such a request can also be made in writing by completing PCA's form entitled "Restriction" and checking the particular box indicating that the service or product was paid for by the patient. If such a request is made PCA must agree with your request.

Minimum Necessary Disclosure. It is the policy of PCA that it shall make reasonable efforts to limit the disclosure to the minimum amount of information needed to accomplish the purpose of the disclosure. It is also the policy of PCA that all requests for PHI must be limited to the minimum amount of information needed to accomplish the purpose of the request. Any unauthorized use or disclosure of PHI be mitigated (to decrease the damage caused by the action) to the extent possible.

Access to Information. It is the policy of PCA that the patient has the right to inspect and copy their PHI. It is PCA's policy that access to PHI must be granted to a patient when such access is requested. Such request shall be submitted in writing by completing PCA's request form entitled "Request for Inspection and/or Copy of Protected Health Information". Patients have the right to receive their PHI through a reasonable alternative means or at an alternative location. Confidential communication channels can be used within the reasonable capability of PCA, (i.e. do not call me at work, call me at home) as requested by the patient. Such request shall be made in writing by completing PCA's form entitled "Confidential Channel Communication Request." Costs associated with the copying of any PHI shall be in accordance with applicable state and federal law. It is the policy of PCA that access to PHI must be granted to a patient's designated personal representative as specified by the patient when such access is requested and authorized by the patient. This designation of a personal representative must be made in writing by completing PCA's form entitled "Designation of Personal Representative."

Amendment of Incomplete or Incorrect Protected Health Information. It is the policy of PCA that a patient has a right to request that PCA amend their PHI that is incorrect or incomplete. PCA is not required to change a patient's PHI and will provide the patient with information about PCA's denial and how the patient can disagree with the denial. A request to amend a patient's PHI shall be made in writing by completing PCA's form entitled "Request for Amendment of Health Information."

Accounting of Disclosures. It is the policy of PCA that an accounting of disclosures of PHI made by PCA is given to the patient whenever such an accounting is requested in writing. The patient has a right to receive an accounting of disclosures of their PHI made by PCA. Such written request for an accounting shall be made by completing PCA's form entitled "Request for Accounting of Disclosures".

Prohibited Activities. PCA is prohibited from using or disclosing a patient's PHI that is genetic information (information about genetic tests or genetic illnesses of the patient or their family members) for the purposes of eligibility, continued eligibility, enrollment, determination of benefits, computing premium or contribution amounts, pre-existing condition exclusion, or other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits. It is the policy of PCA that no employee may engage in any intimidating or retaliatory acts or actions against any person who files a complaint or otherwise exercises their rights under HIPAA regulations. It is also the policy of PCA that no disclosure of PHI will be withheld as a condition for payment for services from the patient or from an entity.

Complaints. It is the policy of PCA that all complaints by employees, patients, providers or other entities relating to PHI be investigated and resolved in a timely fashion. Complaints about this Notice of Privacy Practices or how PCA handles a patient's PHI should be directed to: **Chief Privacy Officer, PCA, 7777 Hennessy Blvd., Suite 103, Baton Rouge, Louisiana, 70808.** If a patient is not satisfied with the manner in which this office handles a complaint, the patient may submit a formal complaint to: **Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg., 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC, 20201.**

Changes to this Notice. PCA reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, PCA is required by law to comply with this notice. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact the Chief Privacy Officer of PCA.

Frequently Asked Questions



1. When and where will the screening take place?

Please call our clinic office at 225-767-6700 to check for available time slots and schedule at your convenience.

Our clinic office is located at the following address:

Louisiana Pediatric Cardiology Foundation
Medical Plaza 1 (attaches to Our Lady of the Lake hospital)
7777 Hennessy Blvd., Suite 103
Baton Rouge, LA 70808

2. What do I need to do for my child to get screened?

A parent/guardian of the student will sign an "Informed Consent and Release" form, along with some demographic information and a short medical history questionnaire that we will provide for you. If possible, please have the form filled out prior to your arrival in order to expedite the check-in process.

3. What tests will be run?

- 12 lead electrocardiogram (EKG)
- Limited echocardiogram (ECHO) to assess heart size and structure

***There will be no needles, blood work, radiation exposure, or sedation.

4. How long with the screen take?

The screen is approximately 15-20 minutes. Unforeseen problems may occur, so please be patient if the screening process runs longer than the estimated time.

5. What is the cost?

There is no cost and we will not obtain or bill your insurance. The value of this free test is approximately \$150 - \$200/student.

6. What if I want to pay or make a donation to help defer costs?

You can make a tax deductible donation to Louisiana Pediatric Cardiology Foundation on the day of the screen. The foundation is a registered public not for profit 501c(3) organization whose purpose is to provide financial aid to families of children needing heart surgery or cardiac-related medical intervention.

7. What is Hypertrophic Cardiomyopathy (HCM)?

Hypertrophic Cardiomyopathy (HCM) is a genetic heart condition that causes a thickening of the heart wall, leading to the obstruction of blood flow and erratic heart beat. It is the leading cause of sudden death in young people.

8. What are common symptoms of Hypertrophic Cardiomyopathy (HCM)?

Not all patients will necessarily experience symptoms of HCM. However, some of the symptoms associated with HCM may include chest pain, fatigue, dizziness, heart palpitations, lightheadedness, fainting (especially after exercise), or shortness of breath.

9. How can Hypertrophic Cardiomyopathy be detected?

Initial signs of HCM can be detected through an electrocardiogram (EKG). The diagnosis can also be made by utilizing an echocardiogram (ECHO), which is an ultrasound of the heart.

10. What is an electrocardiogram (EKG)?

An EKG is a test that measures the electrical activity of the heartbeat. With each beat, an electrical impulse (or “wave”) travels through the heart, causing the muscle to squeeze and pump blood from the heart. The EKG displays the amount of time it takes the wave to travel from one part of the heart to the next, showing if the electrical activity is normal or slow, fast or irregular. The EKG can also determine if parts of the heart are too large or are being overworked.

11. What is an echocardiogram (ECHO)?

An ECHO is a technique that sends sound waves (like sonar) into the chest to rebound from the heart’s walls and valves. The recorded waves show the shape, texture, and movement of the valves. The ECHO also shows the size of the heart chambers and how well they are working.

12. When do I get my results?

A pediatric cardiologist will read every test the week following the screens. All NORMAL test results will be mailed to the patient’s family. If the test results happen to be ABNORMAL, we will communicate the results to the primary care physician indicated on the history form and the parent/guardian of the student directly to discuss necessary follow-up. Please allow 2-3 weeks to receive the NORMAL letters.

13. My child has received both an electrocardiogram (EKG) and echocardiogram (ECHO) in the past by someone other than LPCF. Does he/she need to be screened again?

LPCF recommends that high school athletes be screened every other year. If your child has received a screen within the past two years, please give us a call at 225-768-2590. If the screen was performed by someone other than LPCF, we will need to know the doctor/organization who conducted the screen and when the screen was done in order for you to gain sports clearance. (NOTE: Routine blood pressure and checkup does not constitute a Heart Screen. EKG and ECHO must be included.)

14. What is the likelihood my child has the most common cause of sudden cardiac death?

The frequency of Hypertrophic Cardiomyopathy ranges from 1:500 to as rare as 1:5000. We expect to identify one child per 1000 screened.

15. Will my child’s school or coach get a copy of the results?

No. Your privacy is protected in the same way as if you were seeing a physician for a typical appointment.

16. What does it mean to have an ABNORMAL screen?

If your child has an ABNORMAL screen, you will work with your primary care physician on a plan of care. Many students ultimately are cleared.

17. What does a NORMAL screen mean? Does it mean my child has no risk for any cardiac issues?

A NORMAL screen rules out over 65% of the cardiac causes of sudden cardiac death. The screen does not completely rule out all causes, but does focus on the most common.

18. Who do I contact if I have additional questions or want to participate as a healthcare provider?

If you have any questions, please feel free to call our foundation line at 225-768-2590.

Our main office address is:

Louisiana Pediatric Cardiology Foundation
2137-A Quail Run Drive, Suite A
Baton Rouge, LA 70808