Nervous System Test (Autonomic Testing)

Clinic / Hospital Information			
Name:			
Address:			
Contact Number:			
Evaluator's Name:			
Title / Position:			
Date of Evaluation:			
Time of Evaluation:			
Patient Information			
Name:			
Age:			
Gender:	Male	Female	Other:
Date of Birth:			
Patient ID:			
Referring Physician:			
Medical History			
Current Medications:			
Past Medical History:			
Symptoms Indicating Autonomic Dysfunction:			
Family History of Neurological Disorders:			

Purpose of Evaluation
Reason for Testing:
Specific Symptoms / Concerns:
Autonomic Testing Procedures
1. Heart Rate Response to Deep Breathing
Instructions: Patient breathes deeply at a specified rate, and heart rate variability is measured.
Findings:
2. Valsalva Maneuver
Instructions: Patient forcefully exhales into a mouthpiece against a closed airway.
Findings:
3. Tilt Table Test
Instructions: Patient's blood pressure and heart rate responses are measured upon tilting.
Findings:
4. Sudomotor Testing (QSART)
Instructions: Measures the volume of sweat produced in response to a chemical stimulus.
Findings:

5. Thermoregulatory Sweat Test		
Instructions: Body's sweat response is visualized using a color-charging indicator.		
Findings:		
6. Skin Biopsy for Small Fiber Neuropathy		
Instructions: A small skin sample is taken to examine the small sensory nerves.		
Findings:		
7. Blood Pressure Response to Posture Change		
Instructions: Blood pressure is measured in lying, sitting, and standing positions.		
Findings:		
Overall Assessment		
Summary of Findings:		
Impression:	Normal Autonomic Function	Abnormal Autonomic Function
Specific Areas of Concern:		

Recommendations
Further Diagnostic Testing:
Referral to Specialists:
Therapeutic Interventions:
Follow-Up: Scheduled As Needed
Evaluator's Signature:
Date:

Patient Consent for Evaluation

I, _________________________________, hereby consent to the autonomic testing procedures as described above

Patient's Signature:
Date: