Please affix patient label or complete details below.

Full name:

Hospital number:

NHS number:

DOB:

PIC 261a: patient agreement to PI 261 - head up tilt testing (HUTT)

Admission details		
Referring consultant:	Date and time of test:	NHS / PP
Primary reason for referral:		

All personnel completing the care pathway – please sign below (all student /trainee entries need a counter signature)

Signature	**Print name**	**Initials**	**Job title**

Pre-test checklist				
Pre-test vital				**Initials when completed**
Heart rate: BPM	BP: mmHg	Height: cm	Weight: kg	
Clinical assessment				
Diabetic: Yes / No Type 1 / Type 2 Diet / Tablet / Insulin				
Asthma: Yes / No Inhalers: Yes / No If yes ensure inhaler is present for test				
Allergies: Yes / No If yes, please list details:				
Pregnancy status: Yes / No If yes, are they within 1st trimester (first 12 weeks) : Yes / No				
Any vasodilator drug (eg sildenafil) in the previous 24 hours: Yes / No If so, please document:				
Does the patient have any ongoing or previous cardiac condition(s): Yes / No If yes, please list condition(s)				
Dentures present: Yes / No If yes: Upper / Lower				
Has the patient arranged suitable transport, post-test: Yes / No				
Maintain fluid input as per nil by mouth protocol DN620:				

	Date	Time
Eat		
Fluid		
Caffeine		

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Royal Papworth Hospital
NHS Foundation Trust

Does the patient have any other contra indictaed conditions for tilt testing? Yes / No Details:	

<table>
<tr><td colspan="3">Test results</td></tr>
<tr><td colspan="2">GTN used within the protocol: yes / no

Dose: Time administered:
Administered by:</td><td>Initials when completed</td></tr>
<tr><td colspan="2">Tilt test results: Positive / Negative</td><td></td></tr>
<tr><td colspan="2">Type of response: Vasodepressor / cardio-inhibitory / mixed / POTS / Other (detail below)</td><td></td></tr>
<tr><td colspan="2">Post tilt test</td><td></td></tr>
<tr><td>Negative Test Result
• Patient advised to drink water and eat a light snack.
• Patient observed in clinic E sub wait area for 10 minutes.
• Patient subsequently advised they can leave.</td><td>Positive Test Result
• Patient seen to drink water and consume a light snack.
• Monitor observations until symptoms resolve and patient has returned to a resting state.
• Recover patient in the tilt room and onward to clinic E sub wait area if accompanied.</td><td></td></tr>
<tr><td colspan="2">Escalation of care</td><td></td></tr>
<tr><td colspan="2">Escalation of care
Yes / No Detail:</td><td></td></tr>
<tr><td colspan="2">Admitted to day ward for monitoring:
Yes / No Detail:</td><td></td></tr>
<tr><td colspan="2">Any other medical advice or assistance:
Yes / No Detail:</td><td></td></tr>
<tr><td colspan="2">Onward care plan</td><td></td></tr>
<tr><td colspan="2">Copy of the results and discharge letter should be given to the patient
Copy to referring PP consultant ☐ Copy to EMR ☐</td><td></td></tr>
<tr><td colspan="2">Check transport home is availiable. Patient should not drive for the remainder of the day</td><td></td></tr>
<tr><td colspan="2">Stress the importance of drinking to rehydrate</td><td></td></tr>
<tr><td colspan="3">Signature…………………………………… Print Name………………………………………………

Time and date……………………………………………………………………………………………</td></tr>
</table>

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PIC 261: patient agreement to PI 261 - Head up tilt testing (HUTT)

Statement of patient

Please read the patient information and this form carefully. If the treatment has been planned in advance, you should already have your own copy of which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

Yes No

☐ ☐ **I agree** to the procedure or course of treatment described on this form and have read this information leaflet on Head up tilt testing (HUUT) (PI 261) and had the opportunity to ask questions.

☐ ☐ **I agree** to the use of photography for the purpose of diagnosis and treatment and I agree to photographs being used for medical teaching and education.

- **I understand** what the head up tilt test is and the symptoms that led to me being referred for it.
- **I understand** that alternative tests to look into my symptoms exist and the benefits of the head up tilt test has over those other tests has been explained.
- The mechanisms how the test is using blood pooling in the legs and how this is situation is used with a tilt test has been explained.
- **I understand** the risks of the procedure include black outs and associated symptoms such as nausea, vomiting, headaches and visual disturbances.
- **I understand** that there is a risk of low blood pressure and or heart rate becoming very low. It has also been explained how we rectify it in this situation.
- **I understand** the test can be stopped at any time, but if stopped, it cannot be restarted.
- **I understand** that the test will not be using any local anaesthetic and the plan is not to put any needles or cannulas in but a GTN spray may be needed at the 10 minute mark of the test.
- **I understand** that I cannot drive for the remainder of the day after the test.

Patient signature: ………………………………………

Date: ………………………………………………………

Name (PRINT): ……………………………………………

Confirmation of consent

(To be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance).

On behalf of the team treating the patient, I have confirmed with the patient that they have no further questions and wish the procedure to go ahead.

Signed: ……………………………………………………

Date: ………………………………………………………

Name (PRINT): ……………………………………………

Job title: …………………………………………………