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Patient Information for Tilt Table Test

Your doctor has referred you for a tilt table test. Such a test is performed to examine collapse states and attacks of sudden loss of consciousness (syncope) more closely. Occasionally a tilt table testing is also conducted to examine patients with extreme variations in blood pressure more closely.

Instructions for a Tilt Table Test:

1. Please arrive on time.
2. Do NOT eat or drink anything 4 hours prior to your appointment.
3. Take all your medications as prescribed. Unless otherwise instructed by your physician.
4. **If you are a diabetic**
5. Wear comfortable clothing.
6. It is best NOT to wear jewellery or valuables.
7. If you have any questions about this procedure please write them down and discuss at the pre-test consultation.

A Tilt Table Test involves lying on a bed with a footboard and being tilted at different angles for certain periods of time.

A Tilt Table Test is used to evaluate the cause of unexplained fainting spells or severe light headedness. The procedure is also used to evaluate heart rhythm, blood pressure, and symptoms with change of position.

A Tilt Table Test takes approximately 1 hour so plan to be longer with pre-test consultation and recovery time.

It is best to bring a driver to the test. Although you are usually able to drive yourself home, depending on your symptoms after the test, Doctor might recommend you have a designated driver take you home. On rare occasions, you may need to stay in the hospital.

Examination and treatment method

You will be asked to sign a form that gives the doctor permission to do the test. Then, you will lie on a special bed with a foot-board and a motor that allows your doctor to tilt the bed at different angles. A nurse will start an intravenous line (IV) in your arm to give you medications and/or fluids during the procedure if required. The nurse will connect you to monitors (for monitoring the electrocardiogram, blood pressure, and any heart rhythm changes). You will be awake but asked to lie calmly and keep your legs still. The goal will be to reproduce your symptoms and see how your heart rate, rhythm, and blood pressure respond. You may feel no symptoms at all; you may feel lightheaded, dizzy, nauseous, palpitations, blurred vision, or you may faint, however, you will be continuously monitored and under constant medical care and supervision. It is important to immediately report any symptoms that you experience.



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To begin you will lie flat. Then you will be tilted. After being tilted for 20 minutes you will receive 1 spray of Nitro-Spray in your mouth and continue to be tilted, this may be repeated. During this process, your blood pressure and heart rate will be checked frequently. Remember to report any symptoms. If you pass out you will lie down (without a tilt) right away. If you have no symptoms you will be monitored for a little while longer.

After your procedure, Doctor will go over the results of your test and she will tell you if you are able to return home or under rare circumstances will need to stay at the hospital.

Potential complications

Complications of tilt table testing are extremely rare. Should an arterial cannula be placed, small bruises may occur at the puncture site in rare cases. Any episode of fainting is not to be considered as a complication because it has often triggered by the test.

However, this category also includes the rare complications that can lead to some permanent damage or very rarely even to death.

After the examination

If abnormal findings are encountered during the tilt table test, which require further investigations or measures, we will discuss the further steps with you.

Patient Consent Form for Tilt Table Testing

Please say/ask if you do not understand something or if something seems to be important that was not mentioned in this document or in the personal consultation with your doctor.

Dr Ratnayake held an informed consent discussion with me. I have understood the information provided to me and with all questions answered I _____ consent to a Tilt Table Test and any follow up procedures that may become necessary.

Signature of patient: _____ Date: _____

Signature of doctor: _____ Date: _____

Consent to data collection and evaluation

I agree with the collection and analysis of scientific data of my treatment in an encrypted, electronic form. If necessary, the traceability of data for quality assurance is ensured. We assure you with an unrestricted right of access to inspect the data archived about you.

Signature of patient: _____ Date: _____