



UPRIGHT TILT TABLE TEST

Name: _____ **Test Date:** _____

Physician: _____ **Appointment Time:** _____

Location: _____ **Arrival Place:** _____

An Upright Tilt Table test has been scheduled for you. Please report to the hospital at the time indicated above.

- **DO NOT EAT OR DRINK ANYTHING FOUR (4) HOURS** before the appointment time.
- If you are on any medications please call our office at (616) 949-8554 for special instructions.
- Please allow four hours for the test to be completed.

If you have any further questions or concerns, please do not hesitate to call and speak with the nurse.