

Request for Tilt Table Test

Patient's details:

First Name	<input type="text"/>	Last Name	<input type="text"/>	P.H.N	<input type="text"/>
Date of Birth	<input type="text"/>	Sex	<input type="text"/>	Phone	<input type="text"/>
Address	<input type="text"/>				

Diagnosis / Clinical History:

Syncope

Comments

Ref. MD	<input type="text"/>	Copy to	<input type="text"/>
Date	<input type="text"/>	Study Date	<input type="text"/>

You may send this form by one of the following methods

URL: <http://dr.ly> Email: contact@dr.ly

- Save this form and email to: contact@dr.ly
- Print this form and fax to: (306)-585-3993
- Mail this form to the above address