

Cold Stimulation Test Template

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____ dd / mm / yyyy

Medical Record Number: _____ Date of Test: _____ dd / mm / yyyy

Healthcare Practitioner: _____

COLD STIMULUS:

Cold Stimulus Type

Cold Water Immersion Cold Compress Application

Water Temperature (if applicable): _____ Duration of Exposure: _____

PRE-TEST BASELINE MEASUREMENTS:

Resting Blood Pressure (mmHg): _____ Resting Heart Rate (bpm): _____

POST-TEST MEASUREMENTS:

Post-Cold Exposure Measurements:

Blood Pressure (mmHg): _____ Heart Rate (bpm): _____

Observations

Results

Interpretation

Conclusion

Recommendations

Follow-Up

Healthcare Practitioner's Signature

Patient's Acknowledgment: I, the undersigned, understand the purpose of the Cold Stimulation Test and consent to undergo the procedure.

Patient's Signature

Date: _____ dd / mm / yyyy