

SENSORY PERCEPTION TEST

Clinic No.						
ID No.						
Visit Type					VISIT	

PART I: IDENTIFICATION

1. Patient's NAME CODE:

2. Date of procedure:
Day Month Year

3. stress type: (1) (2)
Physical Mental

4. Check here if **Marstock** not performed? (1)

Reason procedure was not performed: (Check all that apply.)

A. Physician refused (1)

B. Patient refused (1)

C. Procedure contraindicated (cardiac reason) (1)

D. Procedure contraindicated (physical disability or other reason) (1)

E. Equipment unavailable (1)

F. Equipment problem (1)

G. Other (1)

↓

Specify: _____

6. Research Coordinator:
 Signature _____ PIMI Staff No.: _____

DO NOT COMPLETE REST OF FORM. SEND ONLY PAGE 1 TO CCC.

ID No.			-			
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ART II: MEASUREMENTS.

7. Baseline measurements prior to stress (° Centigrade):

A. File Name B

B. Coolness Threshold (CT) BLCT

C. Warmth Threshold (WT) BLWT

D. Warm-Cold Difference (WCDT) -- BLWCDT

E. Cold Pain Threshold (CPT) BLCPT

F. Hot Pain Threshold (HPT) BLHPT

8. Measurements after stress (° Centigrade):

A. File Name ---- P

B. Coolness Threshold (CT) MSC.T

C. Warmth Threshold (WT) MSWT

D. Warm-Cold Difference (WCDT) MS.WCDT

E. Cold Pain Threshold (CPT) MSCPT

F. Hot Pain Threshold (HPT) MSHHP

ART III: ADMINISTRATIVE MATTERS

9. Was this a valid procedure (1) (2)
Yes NO
↓

A. Explain _____

10. Print-out included: (1) (2)
Yes NO

11. Marstock Procedure Technician:
Name : _____ PIMI Staff No.: ---- . _____

12. Research Coordinator:
Signature: _____ PIMI Staff No.: ---- . _____

13. FOR CCC USE
Print-out (1) (2)
Yes No

ID No.			-					
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