



Vestibular Testing Referral

Sydney Fax #: 1-833-451-3658

QEII Dickson #: 1-833-417-9231

Hospital Card Imprint

Name: Last _____ First _____ Middle _____

Date of Birth: ____/____/____ Sex: M F Other _____
d m y

Address: _____ Apt. #: _____

City: _____ Province: _____ Postal Code: _____

Tel: (Home) _____ (Cell) _____ (Work) _____

Email: _____

Next of Kin: _____ Phone: _____

Health card #: _____ Province: NS or _____ Expiry Date: ____/____/____

RCMP #: _____ Other or Country Name: _____ VAC-TAPS #: _____ Armed Forces #: _____

FAMILY DOCTOR

Name: _____

Address: _____

Postal Code: _____ Tel: _____

REFERRAL SOURCE: _____

Company/Agency Name: _____

Address: _____

Postal Code: _____ Tel: _____

REFERRAL FOR: (only check tests you are requesting)

<p>Videonystagmography (VNG) Test:</p> <p><input type="checkbox"/> Calorics: <input type="checkbox"/> Water <input type="checkbox"/> Air</p> <p><input type="checkbox"/> Oculomotor (gaze, saccades, tracking, optokinetics)</p> <p><input type="checkbox"/> Positional Test</p> <p><input type="checkbox"/> Dix-Hallpike</p>	<p><input type="checkbox"/> Vestibular Evoked Myogenic Potentials (Vemp) Test</p> <p><input type="checkbox"/> Video Head Impulse (vHIT) Test</p> <p><input type="checkbox"/> Posturography Test (QEII Dickson Site)</p> <p><input type="checkbox"/> Other: _____</p>
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SYMPTOMS/MEDICAL FINDINGS/CASE HISTORY:

Yes No Is this patient currently taking any medication? Specify medications: _____

Yes No Does this patient have eardrum perforations or ventilation tubes? If yes: Bilateral Right Ear Left Ear

Yes No Does this patient have a hearing loss?

Yes No Does this patient have any visual problems?

Yes No Does this patient suffer from neck/back pain or have artery blockages that would prevent testing from being completed safely?

Yes No Are these services required for employment, insurance or pension purposes?

PLEASE NOTE: It is up to the referring physician to inform patients of the need to stop vestibular suppressing medications 48 hours prior to vestibular testing. For posturography testing, the minimum requirement to perform testing is the ability to stand unassisted without falling for 2-3 minutes. The platform can accommodate patients between 18-136kg and standing 76-203cm.

OFFICE USE ONLY

Date Case History Form Mailed to Patient: _____

Dates Called etc./Results/Comments: _____

Payment Resp. Code: _____

Visit Cost/Reason \$ _____

Appt. Date/Time: _____

Type: _____ Clinician: _____

Date Received: _____