Avenue DIZZINESS & BALANCE Clinic

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www.balancetest.ca info@balancetest.ca

PHYSICIAN REFERRAL FORM

Referring Doctor:		Billing #:	
Phone #:		Fax #:	
Signature:		Date:	MM / DD / YYYY

PATIENT INFORMATION

Patient's Name:		OHIP #:	VC
DOB:	MM / DD / YYYY	Gender:	
Phone #:		2nd Ph. #:	

REASON(S) FOR REFERRAL:

- ◯ Request for Test(s) Only
- ◯ Request for Test(s) and ENT Consultation
- ◯ Request for Test(s) and ENT Consultation, only if necessary.

Tympanic Membrane Intact: ◯ Yes ◯ No

DIZZINESS /BALANCE/VESTIBULAR TESTING

- ☐ Baseline Dizzy Test Battery (Recommended for dizzy patients)
  includes hearing test, ABR, ECOG, CVEMP, VNG & VAT Tests
- ☐ Auditory Brainstem Response (ABR)
- ☐ Electro-Cochleography "Ecoch.G"
- ☐ Video-Nystagmography "ENG/VNG"
- ☐ Vestibular Evoked Myogenic Potentials "VEMP"
- ☐ Video Head Impulse Test "VHIT"
- ☐ Head Rotation Test
- ☐ Advance Tests
  - ☐ Ocular Vestibular Evoked Myogenic Potential "OVEMP"
  - ☐ Video Head Impulse Test "VHIT"

* Hearing Test will be arranged if this referral form does not come with the patient's audiogram within a 3-month of time.

* Please visit www.balancetest.ca for

a) Information for Referring Physician, b)Patient's questionnaire, c) Instruction for patient, d) Patient's consent

This referral form can be downloaded on www.balancetest.ca Once it is completed and signed by physician, please email all documents to info@balancetest.ca or via fax at (416) 440 8014.