Woodbine
DIZZINESS & BALANCE
Clinic

7155 Woodbine Avenue, Suite B102
Markham, Ontario L3R 1A3
Tel: (416) 628 6038 Fax: (416) 628 4006
www.balancetest.ca Info@balancetest.ca

PHYSICIAN REFERRAL FORM

Referring Doctor: _____ **Billing #:** _____

Phone #: _____ **Fax #:** _____

Signature: **Date:** _____

PATIENT INFORMATION

Patient's Name: _____ **OHIP #:** _____

DOB: _____ **Gender:** ☐ Male ☐ Female

Contact Phone #: _____ **2nd Phone #:** _____

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 see special instructions. (Separate page or reverse side)

This referral can be downloaded on www.balancetest.ca Once it is completed and signed by physician, please email it to info@balancetest.ca or fax it to 416 628 4006.