Referring Physician ___________________________ Date ___________________________

This will introduce my patient

For:  □ Diagnosis Only  □ Diagnosis and Treatment

Regarding:  □ Hearing Problem  □ Balance Problem  □ Tinnitus
□ Speech Problem  □ Middle Ear Problem  □ Other ___________________________

Appointment:  □ Monday □ Tuesday □ Wednesday □ Thursday □ Friday
Date ___________________________ at ___________________________ A.M.  □ P.M.

Physician Signature ___________________________ UPIN # ___________________________

If referring for balance evaluation please complete remainder of form.

Please evaluate this patient for complaints of dizziness or balance difficulties. The following general medical information and history is intended to allow more thorough evaluation of this patient.

History:
□ Stroke  □ Diabetes
□ Neurologic Disease  □ Peripheral Neuropathies
□ Visual Problems  □ Circulatory Problems

Please have patient bring ALL current medications to their appointment.

We appreciate any medical records that may assist us in our evaluation.

Certain medications can influence the body’s response to vestibular tests, thus giving false and misleading results. If possible, please instruct your patient to refrain from taking the following types of medication 24 hours prior to their appointment:

ALCOHOL, ANALGESICS/NARCOTICS, ANTIHISTAMINES, ANTI-EMETIC
or ANTI-VERTIGO MEDS, SEDATIVES OR TRANQUILIZERS

Physical Therapy evaluation if indicated  □ OKAY  □ CALL FIRST
Neurologic evaluation if indicated?  □ OKAY  □ CALL FIRST

(map on back)