



# StopFalls CANADA

## Balance and Hearing Clinic

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### REQUEST FOR CONSULTATION

- ENT Consultation
- Audiology Consultation

**\*\* Please add a brief past medical history of your patient to the referral.**

Last Name:	First Name:
DOB (dd/mm/yyyy):	Sex:
Address:	
City:	Postal Code:
Telephone:	
Health Card Number:	
Referring Physician:	
Diagnosis/ Reason for referral:	

Appointment Date:

Time:

✓ PROCEDURES REQUESTED

(Battery of tests may vary based upon to the age and primary concerns)

<ul style="list-style-type: none"> <li><input type="checkbox"/> Hearing Test (&gt;5 years)</li> <li><input type="checkbox"/> ABR (Auditory Brainstem Response)</li> <li><input type="checkbox"/> Tinnitus Assessment <i>(Audio/ABR/VEMP)</i></li> <li><input type="checkbox"/> Tinnitus Management</li> <li><input type="checkbox"/> Hearing Aid Evaluation*</li> <li><input type="checkbox"/> Hearing Aid Check* <i>*Charge applies</i></li> </ul>	<p style="text-align: center;"><b><u>Dizzy Test Battery</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Advanced Diagnostic Hearing Tests <i>(Audiometry/Impedance/ABR)</i></li> <li><input type="checkbox"/> ECochG (ElectroCocheloGraphy) <i>(Meniere's Disease/Endolymphatic Hydrops)</i></li> <li><input type="checkbox"/> cVEMP <i>(Cervical Vestibular Evoked Myogenic Potentials)</i></li> <li><input type="checkbox"/> oVEMP <i>(Ocular Vestibular Evoked Myogenic Potentials)</i></li> <li><input type="checkbox"/> VNG (Video Nystagmography)</li> <li><input type="checkbox"/> Particle Repositioning Maneuver <i>(for BPPV)</i></li> </ul>
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### Special Instructions

Instruction for VNG: Please see reverse for details

Please check-in at least 15 minutes early to the appointment to complete paperwork

