

Date: [Insert Date]

To: Department of Otolaryngology / Audiology

Facility: [Insert Hospital/Clinic Name]

Address: [Insert Address]

RE: Referral for Vestibular Assessment

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

PHN/Health Number: [Insert Number]

Contact Number: [Insert Phone Number]

Dear Consultant,

I am referring this patient for a formal vestibular assessment and otolaryngology consultation regarding the following symptoms:

Primary Symptoms:

[e.g., Vertigo, imbalance, lightheadedness, oscillating vision]

Onset and Duration:

[e.g., Sudden onset, episodic lasting seconds/minutes/hours, or constant since Date]

Associated Otological Symptoms:

[e.g., Tinnitus, hearing loss, aural fullness - specify Left, Right, or Bilateral]

Aggravating Factors:

[e.g., Head movement, rolling in bed, loud noises, pressure changes]

Medical History & Medications:

[Insert relevant history: e.g., Migraines, hypertension, previous ear surgery, current medications]

Clinical Findings to Date:

[e.g., Results of Dix-Hallpike, Romberg test, Nystagmus observation, or previous Audiometry]

Specific Request:

[e.g., Diagnostic clarity, VNG/ENG testing, VEMP, or Caloric testing]

Thank you for seeing this patient in your clinic. Please notify my office of the appointment date and your findings.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Professional Title]
[Your Clinic Name/Contact Info]