

YOUR NEXT APPOINTMENT IS ON:

Date ___/___/___ Time ___ : ___ am pm
Clinic

Patient Details

First Name _____ Surname _____

Address _____

Phone (H) _____ Mobile _____ DOB ___/___/___

Clinical History

General Testing

- Hearing Test (from 9 months of age)
 - Medicolegal
- Hearing Aid Assessment
- Tinnitus Consultation
 - Tinnitus Management Program
- Cochlear Implant Assessment
- Pre-Employment Hearing Test
- Balance Test (VHIT and VEMP)
 - VNG and Calorics
- Electrocochleography, *Extratympanic* (ECOG)
 - Fistula Test
- Auditory Brainstem Response (ABR)
- Bone Conduction Implant Assessment
- Ear and Hearing Protection

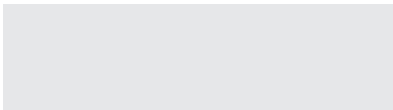
Vestibular Management

- Balance Therapy
(including VHIT and VEMP Assessment)
- Epley's Maneouvre

Referral to:

Name _____

Provider # _____



Signature _____

Copy Report To:

Name _____

Provider # _____

Referral Date ___/___/___



Sydney ENT Consultants

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VIC: Box Hill • East Melbourne • Geelong • Richmond • Wheelers Hill
TAS: South Hobart**