Audiology Referral

Patient Information

Referral Date:

First Name: Last Name: Phone:

Date of Birth: Email: Gender:

Address:

Is this referral urgent? Contact our reception team immediately on (03) 9326 5334 or (03) 9399 9536.

Please Tick The Appropriate Tests Below

Audiology Testing

- **Adult Hearing Test,** including speech recognition and tympanometry (and acoustic reflexes if appropriate).
  - Tympanometry not to be performed if recent middle ear surgery.
- **Children's Hearing Test** (from 6 months old).
- **Cochlear Implant Assessment**
- **Workcover?** **Pension Card Holder?** **Bulk Billed (by Special Request)**

Neuro-otology Testing

- **Basic vestibular protocol –** pure tone audiogram, caloric testing, video head impulse, VNG/oculomotor, oVEMP and cVEMP testing.
- **Central vestibular protocol –** pure tone audiogram, caloric testing, video head impulse, VNG/oculomotor testing (including video recordings with infrared goggles).
- **Acoustic neuroma protocol –** pure tone audiogram, caloric testing, video head impulse, VNG/oculomotor, oVEMP and cVEMP testing.

Optional Adjunctive Tests

- **Caloric Testing** (if information about horizontal semi-circular canal function is required, in addition to the video head impulse test). Note: a comparison between the ears cannot occur if there is ear wax or middle ear pathology (including surgery)**.**
- **ABR Testing** (if a retrocochlear pathology or a condition affecting neural synchrony is suspected and there is no worse than a moderate hearing loss in the high frequencies).
- **cVEMP Threshold Testing** (if superior semicircular canal dehiscence is suspected).
- **Tullio and Fistula Testing** (if superior semicircular canal dehiscence or a perilymph fistula is suspected).
- **Electrocochleography (ECoG)** (if there is no worse than a moderate hearing loss in the high frequencies).

Device Consultation & Fitting

Hearing Aids **Bone Anchored Hearing Aid** **Tinnitus** **Ear Plugs –** Water / Noise / Music **Sleep Plugs**

Reasons for Referral

MRI Results:

CT Results:

Date of Last MRI (Head):

Referrer Information

Name & Contact Details

Provider Number (If Applicable)

Signature:

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