HENDRICK
HEARING HEALTHCARE

Sound advice about your hearing

Evaluation of Vestibular (Balance) Disorders

HEARING TEST: Because both hearing and balance end organs are located in your inner ear, it is important to evaluate your hearing. If you have a hearing loss, your hearing may be monitored periodically. Allow 15-20 minutes for the procedure.

VNG: Videonystagmography or VNG is a more comprehensive vestibular (balance) assessment, evaluating an individual's central and peripheral functions. Special goggles are placed over the eyes for recording purposes using an infrared light. The VNG consists of three general components listed below. Allow 90 minutes for the procedure.

1. Visual tasks: The patient is instructed to watch a red light as it moves in various manners throughout the patient's visual field.
2. Positional tasks: The patient is instructed to lie on a table in several head and body positions to determine if certain positions cause dizziness.
3. Caloric testing: Warm and cool water (or air) are introduced into each are canal for 30 seconds. Eye movement (nystagmus) generated by the changes in inner ear temperature is then measured. The patient may feel lightheaded or slightly dizzy for a few minutes following each irrigation.

CRP: During the VNG the patient may experience vertigo when the head is tilted back on the table. The response is called benign paroxysmal positional vertigo or BPPV. The Canalith Repositioning Procedure or CRP is a procedure used to attempt to correct BPPV. The head is moved into four positions in order to reposition particles which may be floating freely in one of the balance canals in the inner ear. The patient may be seen one week later to repeat the CRP. Allow 10 minutes for the procedure.

WHAT HAPPENS AFTER MY DIZZINESS HAS BEEN EVALUATED? Following the tests, results will be forwarded to your physician who will determine appropriate follow-up.

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BALANCE QUESTIONNAIRE:

Name: _____

1. Did you receive a list of restrictions prior to today's evaluation?_____
2. Did you take any medications in the past 48 hours?_____
   If yes, please list medications:_____
3. Have you ever seen an Ear-Nose-Throat physician?_____
4. Have you ever had ear surgery?____, If so, explain:_____
5. What type of dizziness or balance problem are you experiencing?_____
6. When did the dizziness/balance problem begin?_____
7. Was the onset of the problem gradual or sudden?_____
8. Is your dizziness/balance problem constant or in attacks?_____
   If in attacks, how often do they occur and how long do they last?_____
9. Do you ever feel that you or your surroundings are spinning or turning?_____
10. Do certain head/body movements or certain positions provoke your dizziness/balance problem?_____ If so, describe:_____
11. Do you have a tendency to fall in any particular direction?_____
    Circle all that apply: Right Left Forward Backward
12. Do you use any type of tobacco product?_____ If yes, how often?_____
13. Do you drink alcohol?_____ If yes, how often?_____
14. Were you exposed to any fumes, paint, or chemicals at the onset of the balance problems?_____ If yes, explain:_____
15. Have you ever had a head injury?_____ If yes, explain:_____

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16. Have you previously had testing for dizziness?_____

17. Have you ever had an MRI or CT Scan of your head?_____

18. Have you ever had back or neck injury/surgery?_____

19. Do you have any eye problems such as double vision or cataracts?_____

20. Have you received new eyeglasses or contacts recently?_____

21. Do you ever experience numbness of the face, arms, or legs?_____

22. Do you ever experience difficulty with swallowing or speaking?_____

23. Have you ever had a hearing test? _____ If yes, when?_____

24. Do you have any of the following symptoms?
    Yes No Difficulty hearing? Right Left Both Onset?_____
    Yes No Noise in the ears? Right Left Both Describe:_____
    Yes No Fullness or stuffiness in the ears? Right Left Both
    Yes No Drainage from the ears? Right Left Both

Comments:_____

_____

_____

_____

_____

Authorization for Care: I grant permission to the employees of Hendrick Balance Center to render care to me and to carry out the orders of my attending physician, including consultants, associates and assistants of associates.
Financial Responsibility: I understand that I am responsible for the total charges for services rendered and I agree that all amounts are due and payable to Hendrick Hearing HealthCare upon receipt of services.
Authorization to Release Information: I authorize Hendrick Balance Center to release any medical or other information requested by representatives of local, state, or federal agencies; insurance companies; review agencies; or other organization or entities as may be required for payment of claims which are due Hendrick Balance Center as a result of this visit.

Name:_____ Date:_____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTIES

EFFECTIVE JANUARY 1, 2008

Your name and signature on this form indicate that you have received or have inspected a copy of Hendrick's Notice of Privacy Practices, effective April 14, 2003 on the date indicated below.

If you have any questions regarding the information set forth in this Notice of Privacy Practices, please do not hesitate to contact the Privacy Office at 325-670-7763.

I hereby give my permission to Hendrick Hearing Healthcare to discuss my healthcare with the following person (s):_____.

Printed name of Patient	Signature of Patient	Date
_____	_____	_____
Signature of Patient Representative	Relationship to Patient	Reason Patient Unable to sign
_____	_____	_____

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Today's Date:_____

Patient's Name:_____DOB:_____Age:_____Sex:___

Mailing address:_____Apt#_____Spouse:_____

City:_____State:_____zip:_____

Home Phone( )_____Cell( )_____ SSN#:_____

Employer:_____ Business Phone( )_____

Business Address:_____

REFERRED BY: Phone Book Friend Newspaper Physician Other (Please circle one)

Insurance Information- please provide insurance cards

Primary Insurance Company Name:_____

Policy Holder's Name:_____DOB:_____

Policy Holder's Employer:_____Phone#:_____

Policy#_____Group#_____SSN#_____

Next of Kin not living with Patient

Name:_____Relationship:_____

Address:_____Telephone:_____

Referring Doctor's Name:_____Phone#_____

Are you a First Choice Member?_____

I understand that my Insurance will be filed as a courtesy to me and that I will be responsible for any deductible and/or co pays.

Patient signature_____**Date:**_____

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