Washington University

DIZZINESS AND BALANCE CENTER

Request for Vestibular Testing

Requesting Physician (print):___________________________________ Date: _____________

Patient Name:____ DOB:_____________

Diagnosis Code: (please circle) Test Date/Time: ___________ ___________

(H81.399 peripheral vertigo) (H81.49 central vertigo) (H81.10 BPPV) (H81.20 Vestibular Neuronitis)

(H81.09 Meniere's Disease) (R26.9 Abnormality of Gait) (other__________)

TEST(S) REQUESTED:

	Test	Duration
_____	Video-Oculography (VOG) (includes calorics)	(75 min)
_____	Calorics ONLY	(45 min)
_____	Video Head Impulse Test (vHIT)*	(15 min)
_____	Rotational Chair (includes OKN)	(45 min)
_____	Dynamic Subjective Visual Vertical (DSVV)*	(15 min)
_____	Vestibular Evoked Myogenic Potentials (VEMP)* (cervical and ocular)	(60 min)
_____	Computerized Dynamic Posturography (Platform)*	(30 min)

SPECIAL INSTRUCTIONS: ____

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* May not be covered by some insurance carriers. Patients must self-pay for these exams.

PERMISSION FOR ADDITIONAL TESTING:

_____ Yes, you have my permission to do additional vestibular testing as needed.

_____ Please call referring physician before adding additional vestibular testing.

REQUESTED BY: ____

(Requesting Physician Signature Required)

FAX REQUEST TO: (314) 362-7522

Washington University in St. Louis
School of Medicine

Washington University in St. Louis
Physicians