



Balance Center

Westchester Medical Center

REFERRAL FORM

Westchester Medical Center Health Network

Date: _____

Patient Name: _____

Patient Phone: _____

Diagnosis: _____

- | | |
|---|--|
| <input type="checkbox"/> Central Vertigo/ICD10 H81.4 | <input type="checkbox"/> Peripheral Vertigo/ICD10 H81.319 |
| <input type="checkbox"/> Meniere's Disease/ICD10 H81.09 | <input type="checkbox"/> Vestibular Neuritis/ICD10 H81.20 |
| <input type="checkbox"/> Labyrinthitis/ICD10 H83.09 | <input type="checkbox"/> Vestibular Schwannoma/ICD10 D33.3 |
| <input type="checkbox"/> Other: _____ | /ICD10 _____ |

Testing/Therapy Requested

- Complete Balance Testing (VNG/Post/Rotary Chair and VEMP)
- VNG
- Posturography
- Rotary Chair
- VEMP
- Balance Therapy w/ Vestibular Rehabilitation Specialist

Ordering Physician Name: _____

Signature: _____

Address/Fax from Reports: _____

Please fax this form to 914-493-7853
We will contact patient to schedule
an appointment.



Balance Center at Westchester Medical Center

Katrina R. Stidham, MD
Medical Director

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Clinical Director

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