THE CENTERS FOR ADVANCED ENT CARE
Potomac ENT & Allergy

Appointment Date: _____
Appointment Time: _____

# VNG / CDP Patient Packet

Videonystagmography (VNG) & Computerized Dynamic Posturography (CDP) Tests

## VNG

VNG is used to evaluate patients with dizziness, vertigo, or balance dysfunction. The balance center of your inner ear (the vestibular system) and eyes movements are connected through the vestibulo-ocular reflex. With this reflex, the vestibular system monitors the position and movements of the head in order to maintain stable vision. During the VNG test, eye movements are recorded, and give information about the central and peripheral balance system. VNG testing consists of three parts: oculomotor evaluation, positioning/positional testing, and caloric stimulation of the vestibular system. The test takes approximately 1.5 hour (90 minutes) to complete. Some dizziness is normal with VNG testing, and typically is of short duration. It is advised to bring someone to the appointment to drive you home, should you feel unwell afterwards.

## CDP

CDP is well documented in the clinical and scientific literature as an objective method of differentiating sensory, motor, and central adaptive functional impairments of balance (the test indicates which parts of your balance system you rely on most). The functional impairment information provided by CDP is complementary to the traditional diagnostic approaches to balance disordered patients (VNG, rotary chair, MRI, etc.) that focus on individual, isolated anatomical components. The patient is placed on a platform with a safety harness in place and faces a visual surround. Sensors within a platform footplate measure the force exerted from the feet when the patient's center of gravity is displaced (*the test is performed without shoes on*; therefore, wear/bring socks or there are sanitary foot covers available).

**Please discontinue use of the following medications for 48 hours prior to your test:**

· Allergy pills
· Tranquilizers (Valium, Librium, Xanax, etc.)
· Sedative pills (all sleeping pills or tranquilizers)
· Decongestants/Antihistamines (Benadryl, Sudafed, Dimetapp, Chlor Trimeton, Seldane)
· Pain pills
· Diet pills
· Nerve/muscle relaxant pills (Robaxin, Valium)
· Dizziness pills (Antivert, Meclizine, Bonine, ear patches, etc.)
· Aspirin or aspirin substitutes (Tylenol, etc.)
· Narcotics/Barbiturates (Codeine, Demerol, Percodan, Phenobarbital, antidepressants)
· Discontinue all medication for 48 hours prior to the test, except "maintenance" medications for your heart, blood pressure, diabetes, or seizures, and any medications deemed by your physician to be necessary.

Please consult your physician with any questions. It is helpful if you bring a list of the medications you take regularly, or even the medications themselves. Medications can be resumed immediately following the VNG testing procedures. If there are any questions about the test or medication, please contact your doctor or our office at 703-499-8787.

**Additional instructions:**

· **If you need help translating into your language, please bring someone along to the appointment.**
· Wear comfortable clothing and flat, supportive shoes.
· Try to get plenty of sleep and be fully rested.
· Clean face, no facial or eye makeup.
· If you are a contact wearer, be prepared to remove them if it interferes with the testing.
· No solid foods for 2 to 4 hours before the test.
· No coffee, tea, or cola after midnight on the day of the test.
· No alcoholic beverages/liquid medication containing alcohol 48 hours before the test.

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Patient Name: _____

DOB: _____ Acct: #_____

**Patient Questionnaire Please complete *before* your appointment and bring it with you.**

**When you are "dizzy" do you experience any of the following sensations/symptoms?**

**Check all that apply**

- ☐ Spinning (Vertigo)
- ☐ Lightheadedness
- ☐ Swimming Sensation in the Head
- ☐ Blackout / Loss of Consciousness
- ☐ Hearing Loss
- ☐ Headache
- ☐ Tinnitus (Noise in Head/Ears)
- ☐ Full Feeling in the Ear(s)
- ☐ Nausea / Vomiting
- ☐ Tendency to Fall to the (circle one):
  Right Left Forwards Backwards All Directions
- ☐ Pressure in the Head
- ☐ Sensitivity to Light / Noise
- ☐ Double Vision
- ☐ Numbness of Face or Arms / Legs
- ☐ Blurred Vision or Blindness
- ☐ Weakness in Arms / Legs
- ☐ Confusion
- ☐ Difficulty with Speech
- ☐ Difficulty with Swallowing
- ☐ Tingling Around the Mouth

**Describe your "dizziness" attack(s):**

Is your dizziness constant or periodic? _____

When did first attack occur? _____

How long since last attack? _____

How often do the attacks occur? _____

How long do they last? _____

What, if any, warning signs do you have before an attack? _____

_____

Does dizziness occur in certain body / head positions? _____

Are you completely free of dizziness between attacks? _____

Do you know of any possible causes for your dizziness? _____

_____

Do you know of anything that will stop your dizziness or make it worse? _____

_____

Were you exposed to any irritating fumes, paints, etc.? At the onset of your dizziness? _____

_____

Have you changed medications prior to the onset of your dizziness? _____

Have you recently gotten new glasses / contacts? _____

Have you seen any specialists regarding your dizziness? _____

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**What brings on your dizziness? Check all that apply:**

- ☐ Exertion or Overwork
- ☐ Heavy Lifting or Straining
- ☐ Missing a Meal
- ☐ Going from Sitting/Lying Down to Standing
- ☐ Looking Up
- ☐ Bending Over
- ☐ Quick Head Movements
- ☐ Turning Over in Bed (Right or Left)
- ☐ Stress
- ☐ Loud Sounds
- ☐ Walking Down the Aisle in the Grocery Store
- ☐ Menstrual Cycle

**Health Questions. Check all that apply.**

Do you or have you ever...

- ☐ Had Ear Surgery
- ☐ Had Difficulty with Hearing
- ☐ Had Fluctuating Hearing Loss
- ☐ Had Pain/Discharge in Ears
- ☐ Been Exposed to or Work in Loud Noise
- ☐ Allergies
- ☐ Use Tobacco
- ☐ Use Alcohol
- ☐ Had Cold Sores/Shingles/Herpes Simplex Virus
- ☐ Had an Autoimmune Issue Such as Rheumatoid Arthritis
- ☐ Had an Acute Ear/Sinus Infection
- ☐ Have Diabetes
- ☐ Have High or Low Blood Pressure
- ☐ Headaches
- ☐ Neuropathy
- ☐ Arthritis
- ☐ Back/Neck/Knee Pain
- ☐ Orthopedic Surgery

**Please list any medications/supplements you take regularly:**

_____
_____
_____
_____
_____
_____

**Please describe your dizziness in your own words and note any additional information that may be helpful in treating your dizziness.**

_____
_____
_____
_____
_____
_____
_____
_____

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## Cancellation

**Please give us at least 72 hours notice if you need to cancel or reschedule this test for any reason and plan to arrive 15 minutes before your appointment time.**

**Late arrival or failure to give 72 hours notice results in a $150.00 fee!**

## Medical Records

In order to provide you with the best care, we ask that if you have any medical records regarding your dizziness or balance problem, please have your primary care doctor or specialist send them to our clinic prior to your initial appointment. This is not required to undergo testing but aids our audiologist in evaluating your condition. This includes past ENG's, VNG's, EMG's, MRI's, CT scans, hearing tests or any other related studies. If you don't know how to obtain or send your medical records, call our office before your appointment and we will be glad to help locate them for you.

## Insurance

Videonystagmography (VNG) and Computerized Dynamic Posturography (CDP) are covered by most medical insurances. Please check your policy for coverage details including deductibles and copayments. Insurance co-payments are due at the time of visit.

**CPT Code & Test Cost:**

- 92549; Computerized Dynamic Posturography (CDP, SOT, MCT, ADT)
  - $100 if not covered by insurance
- 97750; Modified Clinical Test of Sensory Interaction in Balance (mCTSIB)/Limits of Stability Test
  - $100 if not covered by insurance

By signing below, I understand that the above test(s) or treatment(s) may not be covered by my insurance company and I am responsible for the above charge(s) each time the test(s) or treatment(s) are performed. I am also aware that Potomac ENT will bill my insurance carrier and if it is not covered at 100% or a covered benefit, I will be responsible for all charges.

_____ _____

Patient Name (Sign) Date

_____

Patient Name (Print)

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I, _____ authorize Potomac ENT, a division of CADENT to perform the following procedure:

**VNG: Videonystagmography**

**CDP: Computerized Dynamic Posturography**

I _____ also understand that if I do not cancel my appointment in 72 hours, **I will be responsible for $150.00 cancellation fee.**

Patient/Responsible Signature _____ Date: _____

Witness: I have explained these instructions, alternatives, and expectations to the patient, and believe he/she has been adequately informed and has consented.

Witness Signature_____ Date: _____