The Hearing Center of Lake Charles, Inc.
Hear today. Hear tomorrow.

The office of Dr. Ram Nileshwar, Au.D., CCC-A, FAAA
Board Certified in Audiology

Patient Instructions

Your physician has ordered VNG diagnostic testing. A VNG is an examination of the "inner ear" balance system. It is performed when patients report dizziness, vertigo, and/or equilibrium problems to their doctors. This exam is painless; however, mild dizziness may be experienced during certain parts of the test. You should arrange to have a driver available following the test to drive you home.

During this test, you will wear special goggles that will record eye movements from the balance system. It tells the eyes to move in a special way. These special eye movements are recorded on a computer. Most parts of the test require the patient to move into different head and body positions. The last part of the test involves irrigating the ears with cool and warm air to evaluate each balance organ separately. The whole procedure usually requires 90 minutes to 2 hours.

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY!

Do not eat for 2 hours before the test. If you are diabetic, do NOT alter your current diet or diabetic medication regimen. Wear comfortable clothing, as you will be changing positions on the exam table. Additionally, you may choose to wear flat/low-heeled shoes in the event you feel off balance or dizzy at the conclusion of the evaluation. Do not apply foundation or eye make-up before the test. Remove contact lenses before the exam.

Certain medications can influence the body's response to the test and interfere with test results. It is important that you ***DO NOT take any of the following for 48 hours prior to the test in order to achieve the best and most precise results:***

- Nicotine (cigarettes, chewing tobacco, snuff, cigars, pipes)
- Caffeine (soft drinks, coffee, tea, diet pills containing caffeine)
- Anti-Vertigo or Dizziness medicine (Anti-vert, Ru-vert, Meclizine, Valium, Dramamine, Transderm Scopolamine)
- Sedatives and sleeping pills (Halcion, Testoril, Nembutal, Secondal, Dalmane, Ambien or any sleeping pill or medications that list drowsiness as a side effect)
- Analgesics – Narcotics (Codeine, Demerol, Phenaphen, Tylenol with codeine, Percocet, Darvocet, Hydrocodone, Percodan, Lorcet, Oxycodone, Oxycontin, Morphine, MS contin, Norgesic, Norgesic Forte, Propoxyphene, Duragesic, Hydromorphone, Hydoxyzine, Ultram, Soma, Skelaxin, Stadol, Ultracet, Zanaflex, Flexeril, Norflex, Robaxin, Salsalate, and others listed below)
- Anti-histamines and cold and sinus medicines (Chlor-trimeton, Dimetapp, Disophrol, Benadryl, Actifed, Teldrin, Triaminic, Hismanol, Claritin, Zyrtec, Singulair, Allegra, diphenhydramine, Alavert, any over the counter cold remedies)
- Anti-nausea medicine (Atarax, Dramamine, Compazine, Antivert, Bucladin, Phenergan, Thorazine, Scopalomine, Transdermal, Zofran)
- Anti-seizure medicine (Dilantin, Tegretol, Phenobarbital)
- Tranquilizers (Valium, Librium, Atarax, Vistaril, Serax, Ativan, Librax, Tranxene and Xanax)
- Alcohol (beer, wine, cough medicine)
- You may take blood pressure medications, thyroid medication, regular Tylenol, insulin/diabetes meds, Estrogen, Heart Meds, glaucoma drugs, asthma inhalers, antibiotics, Imodium and Pepto Bismol, etc.
- You should first seek approval from your prescribing physician before you stop any of these medications.
- If you are unable to contact your physician and discontinue use of the medication, please call 474-3880 to determine if the test results will be valid.

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If you are unable to contact your physician and discontinue use of the medication, please call 474-3880 to determine if the test results will be valid.

Failure to comply with these instructions will compromise test results and may result in your test being rescheduled for another day.

Please remember that we have set aside 1 ½ to 2 hours for your appointment. **Please notify the office at (337) 474-3880 at least 48 hours before the test if you cannot keep the appointment**.

Additional medications interfering with the testing follow. If you are not sure of any medications not listed that you have been prescribed, please call us at (337) 474-3880.

Please complete all forms and bring them to your appointment to save time.

ADDITIONAL MEDICATIONS INTERFERING WITH BALANCE VNG TESTING

Acetaminophen/Codeine	Depakote	Lioresal	Proxyphene	Trifluoperazine HCL
Allegra	Darvon	Limbitrol, Limbitrol DS	Pulvules	Trimipramine
Alprqazolam	Desyrel	Lorazepam	Oxazepam	Trimethobenamine
Ambien	Diastat	Lovox	Quazepam	Tylenol 3, Tylenol 4
Amoxapine	Diazepam	Mellaril	Remeron	Tylox
Amytriptyline + Chlordiaxepoxide	Dimetabs	Meni-D	Restoril	Ultracet
Anafranil	Diphenhydramine	Marazine	Risperdal	Ultram
Antivert	Dramamine	Meclizine	Risperidone	Xanax
Asendin	Doral	Mesoridazine Besylate	Ritalin	Valium
Ativan	Doxepin	Methlycarbamol	Robaxin	Valproic Acid
Aventyl	Effexor	Methylphenidate HCL	Roxicet	Venlafaxine
Baclofen	Elavil	Metaxalone	RU-Vert-M	Vicodin
Benadryl	Endep	Mirtazapine	Seratraline	Vivactil
Bonine	Escitalopram, Oxalate	Neurontin	Serax	Wellbutrin
Bu Spec	Fexofenadine	Norpramin	Seratraline	Zaleplon
Bupropion HCL	Flexeril	Nortriptyline	Serentil	Zoloft
Buspirone	Flurazepam	Oxycodone	Sinequan	Zolpedem
Celexa	Fluphenazine	Oxycodone + Acetaminophen	Skelaxin	Zyban
Centrax	Fluvoxamine	Oxycodone + Aspirin	Stelazine	Zydone
Certizine HCL	Gabapentin	Oxycodone + Hydrochloride	Surmontil	Zyrtec
Chlordiazepoxide	Gabitril	Oxycontin	emazepam	
Chlorpromazine	Gen-Xene, Tranxene SD	Pamelor	Tigan	
Chlorazepate	Halcion	Paroxtine	Thioridazine	
Citalopram Hydrodomide	Hydrocodone + Bitartrate	Percocet	Thorazine	
Clindex	Imipramine	Percodan	Tofranil	
Clonazepam	Keppra	Phenergan	Tramadol	
Clomipramine	Klonopin	Prazepam	Tramadol HCL	
Compazine	Levetiracetam	Prochlorpera	Transderm	
Cyclobenzaprine HCL	Lexapro	Prmathazine HCL	Trazodone	
Dalmane	Librax	Protriptyline	Tiagabine HCL	
Depakene	Librium		Triazolam	

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Patient Information Sheet

Name: _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Other _____

Address: _____ City, State _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

SS#: _____ Birthdate:_____ /_____ /_____ Age: _____

Occupation: _____ Employer: _____

Referring Doctor: _____ Primary Physician: _____

INSURANCE INFORMATION: (Please give cards to office staff to copy – we must have a copy on file)

Please check any of the following you have had or now have:

☐ Heart Disease	☐ Glaucoma	☐ Stroke	☐ Nausea	☐ Artificial Joints
☐ Ulcer Disease	☐ Depression	☐ Cancer	☐ Back Problems	☐ Multiple Sclerosis
☐ Blood Disorders	☐ Pacemaker	☐ Neck Problems	☐ Asthma	☐ Emphysema/COPD
☐ Infection/Wounds	☐ Tuberculosis	☐ Arthritis	☐ Breathing Problems	☐ High Blood Pressure
☐ Parkinson's Disease	☐ Ringing in ears	☐ Diabetes	☐ Circulation Problems	☐ Epilepsy/Convulsions

Please state briefly the nature of your problem: _____

List all medications you are taking: _____

List any operations you have had: _____

List any medications you are allergic to or have been advised not to take: _____

I understand that evaluation of the hearing/speech system requires the use of specialized instrumentation. During the course of this evaluation, I understand that various earphones will be placed over or in my ears and various probes may be placed in the external ear canal. I agree that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Authorization for assignment of insurance claims and release of medical records which may include: Hearing Test Results and Reports, Ear Impressions, Biographical data and clinic notes is hereby given. This medical information may be disclosed for medical follow-up and care, audiological reporting to source of referral, hearing aid manufacturing, hearing aid repair, and procurement of additional resources for hearing health care. I understand that The Hearing Center will receive compensation for the uses and disclosures that I have authorized and that I am responsible for any amount not covered by my insurance carrier. Filing of insurance is strictly a courtesy and The Hearing Center is not responsible for checking for benefit coverage. I understand I will be billed for any amount not covered by my insurance. I agree to be bound by the above terms and conditions.

I hereby acknowledge that I have also received a copy of the Notice of Privacy Practices for The Hearing Center and I am aware that this authorization for release of medical information may be revoked at any time by signing a revocation form.

_____ _____

Signature of patient or personal representative Date