

**LR 14
CHEAT
SHEET**

Referral Pathways

Choosing the right provider, urgency, and letter content for the dizzy patient

WHY IT MATTERS

Median time-to-diagnosis for dizziness exceeds 18 months in Australia. Patients are routinely referred to the wrong specialty, wait Category-3 times for non-surgical pathology, and lose work, driving, and confidence in the wait. A structured pathway turns "dizziness referral" into a precise clinical question matched to the right provider, in the right timeframe, with the right information.

CORE PRINCIPLES — WHO, WHEN, WHERE

- ▶ Refer based on the **SYNDROME**, not the symptom. "Dizziness" alone does not select a specialty.
- ▶ State the clinical question explicitly in line one of the letter — diagnosis, intervention, or testing.
- ▶ Communicate urgency through the channel that matches the tier (phone for same-day, urgent letter for ≤1 wk).

◆ *A referral letter that does not state a clinical question is triaged badly. State the question in line one — diagnosis, intervention, or testing — before any narrative.*

CONDITIONS GPs CAN MANAGE WITHOUT REFERRAL

Condition	GP-managed first line Refer when
BPPV	Single Epley/Semont resolves 60–80% Refer after 2 failed manoeuvres or atypical nystagmus
Vestibular migraine	SEEDS lifestyle + 3-mo prophylaxis (propranolol, amitriptyline, candesartan) Refer after 2 trials
Vestibular neuritis	Suppressants ≤48 h, taper; vestibular rehab Refer if recovery delayed past 4–6 wks or hearing loss
Orthostatic / drug-induced	Lying-and-standing BP, medication review, non-pharmacological advice Refer if refractory or autonomic features
Acute peripheral vertigo	HINTS exam, suppressants, rehab referral Refer if central HINTS or atypical course
Chronic stable dizziness with diagnosis	Continue rehab; review every 4–6 wks Refer for second opinion if not progressing
Falls with multifactorial dizziness	Medication review, OT/physio, safety-net Refer to vestibular physician or geriatrician if vestibular contribution unclear

URGENCY TIERS — HOW QUICKLY DO THEY NEED TO BE SEEN

Tier	Examples Channel
Tier 1 — Same day (ED / phone)	Central HINTS, SSNHL with vertigo, suspected PCS, severe trauma Phone
Tier 2 — ≤1 week (urgent letter / phone)	Asymmetric SNHL with vertigo, suspected schwannoma, first severe Meniere, recurrent falls Phone or marked URGENT
Tier 3 — ≤1 month (flagged routine)	VM refractory, PPPD diagnosis, suspected unilateral vestibulopathy, diagnostic uncertainty Letter with explicit question
Tier 4 — Routine	Stable chronic dizziness, ongoing rehab need, second opinion Standard letter + self-management resources

FIVE RED-FLAG PRESENTATIONS — SAME-DAY ESCALATION

Red-flag presentation	Action
AVS with central HINTS	Stroke pathway — phone, MRI-DWI
Sudden SNHL with vertigo	Oral steroid <72 h; phone ENT; MRI IAM
Severe occipital headache + acute vertigo	CT angiography — vertebral dissection
Vertigo with fever, meningism	Emergency department — LP, antibiotics

◆ *The bedside vestibular exam takes 5 minutes and resolves the diagnostic question in most dizzy patients. Build it into every dizziness consult.*

WHAT TO INCLUDE IN THE REFERRAL LETTER

- ▶ Clinical question (one line) — diagnosis, intervention, second opinion, or testing?
- ▶ **TiTrATE** — Timing (acute/episodic/chronic), Triggers, Targeted exam findings.

- ▶ **Bedside exam — HINTS, Dix-Hallpike, head impulse, orthostatic BP, gait, nystagmus pattern.**
- ▶ **Trials done — Epley attempts, prophylaxis trialled, medications changed; attach audiogram / MRI / bloods.**

THE VESTIBULAR PHYSICIAN MODEL

A vestibular physician is a GP with vestibular training providing a one-stop diagnostic consult — bedside testing, vestibular function testing, and management initiation. Best for diagnostic uncertainty after structured GP work-up, failed first-line management, suspected PPPD, and complex chronic dizziness. NOT for red flags (require ED) or pure hearing loss without vestibular features (refer to ENT or audiology).

Letter component	What goes here
1. Clinical question	Diagnosis? Management? Testing? One line, opening sentence.
2. Symptom timing	TiTrATE — Timing (acute / episodic / chronic), Triggers, Targeted exam, Episode duration, First episode date.
3. Hearing & otology	Laterality of hearing change, tinnitus, aural fullness, otoscopy. Attach audiogram if done.
4. Bedside exam	HINTS, Dix-Hallpike, head impulse, orthostatic BP, gait, nystagmus pattern.
5. Differential considered	Working diagnosis + next-most-likely options. Shows your framing.
6. Trials & investigations	Epley attempts, prophylactic trials, medication changes, MRI / audiogram / blood results — attach copies.
7. Functional impact + expectations	Driving, work, falls, mood. Travel and telehealth acceptability. DVA / MVA / WC cover.

◆ *Three sentences a triage clinician needs in line one: WHAT is the problem, WHAT have you tried, WHAT do you want from me. If your letter does not answer those in the first paragraph, rewrite the first paragraph.*

COMMUNICATING URGENCY

Provider	Strengths	Refer for
Vestibular physiotherapist	BPPV manoeuvres, vestibular rehab, gaze stabilisation	Persistent imbalance, BPPV manoeuvres, rehab program
Vestibular physician (GP-SI)	Bedside testing + VFT + management initiation	Diagnostic uncertainty, refractory VM, PPPD, complex chronic dizziness
ENT / neuro-otology	Surgical management, hearing + balance combined	Meniere, schwannoma, SCDS, fistula, conductive + vestibular
Neurology	Central nervous system disease	MS, stroke, episodic ataxia, atypical migraine, FND with vestibular features

Tier 1 (same day) — phone the on-call team and document the conversation. Tier 2 (≤ 1 week) — phone or e-mail the receiving service; mark URGENT. Tier 3 (≤ 1 month) — standard letter with explicit clinical question; flag distress or work impairment. Tier 4 (routine) — standard letter; provide self-management resources for the wait.

◆ *Public ENT outpatients categorise non-surgical vestibular dizziness as Cat-3 with 6–12 month waits. For non-surgical questions, a vestibular physician or private vestibular consult often delivers the answer faster than the public referral.*

KEY MESSAGES

- ▶ **Match the syndrome to the provider — not "dizziness" to a generic specialty.**
- ▶ **Vestibular physician = best fit for diagnostic uncertainty and chronic dizziness.**
- ▶ **ENT / neuro-otology = surgical pathology, hearing-and-balance, schwannoma, Meniere intervention.**
- ▶ **Neurology = central disease, MS, episodic ataxia, atypical migraine.**
- ▶ **The referral letter answers WHAT is the problem, WHAT have you tried, WHAT do you want from me.**

◆ **Closing the loop — review every dizzy patient at 4–6 weeks regardless of the receiving clinician's wait. Driving, falls risk, and mood deteriorate measurably during long waits for vestibular care.**