Referral Pathways:

A Structured Approach for General Clinicians

Vestibular Medicine for General Clinicians

Topic 14 of 14

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How to Use This Review

This literature review is part of the Vestibular Medicine for General Clinicians series published by the Australian Dizziness Clinics Education Hub. It is written for general practitioners, hospital generalists, nursing, and allied health staff who assess and manage patients presenting with dizziness.

The review is designed to be read in a single 20–30 minute sitting, or used as a desktop reference. It is supported by an A4 one-page cheat sheet, short-form clinician videos, and audio episodes that cover the same material.

Callout Box Guide

☐ **Key Point:** Foundational concepts and summary statements that anchor the core clinical content of each section.

☐ **Clinical Insight:** Clinically relevant observations for direct application in assessment and management.

☐ **Clinical Pearl:** High-yield memorable clinical points — the take-home messages most likely to change practice.

☐ **Important:** Red flags, emergencies, and critical safety points requiring immediate action.

Table of Contents

I. The Referral Problem in Vestibular Medicine

Dizziness is one of the most common presenting symptoms in general practice and emergency medicine, accounting for roughly 4 percent of all primary-care consultations and 3 percent of all emergency department presentations in Australia [1,2]. Despite this volume, the referral landscape for the dizzy patient is poorly developed. Patients are routinely directed to the wrong specialty, wait months for an opinion, or are sent home without a working diagnosis. Consumer survey data consistently show median time-to-diagnosis exceeding 18 months and a mean of three to four clinicians seen before the correct diagnosis is reached [3].

Three structural problems drive this. First, vestibular medicine sits at the intersection of multiple specialties — ENT, neurology, geriatrics, and rehabilitation medicine — without an obvious owner. Second, the high-volume tertiary services (otolaryngology and neurology outpatients) are oversubscribed and often categorise non-urgent dizziness referrals as Category 3 with waits of six to twelve months. Third, very few first-contact clinicians have been formally trained in the bedside vestibular examination, so the diagnostic threshold to refer is low and the discriminating clinical features that should direct the referral are often not documented [4].

□ **Key Point:** The aim of a vestibular referral is not to confirm that the patient is dizzy. It is to answer a specific clinical question — diagnosis, intervention, or risk-stratification — that cannot be answered in primary care. A referral letter that does not state that question explicitly will be triaged badly.

A structured referral pathway addresses this by (i) classifying the syndrome at first contact, (ii) attempting bedside diagnosis and first-line management, (iii) selecting the correct specialty based on the syndrome rather than the symptom, and (iv) communicating urgency clearly. The remainder of this review provides that structure for the Australian context.

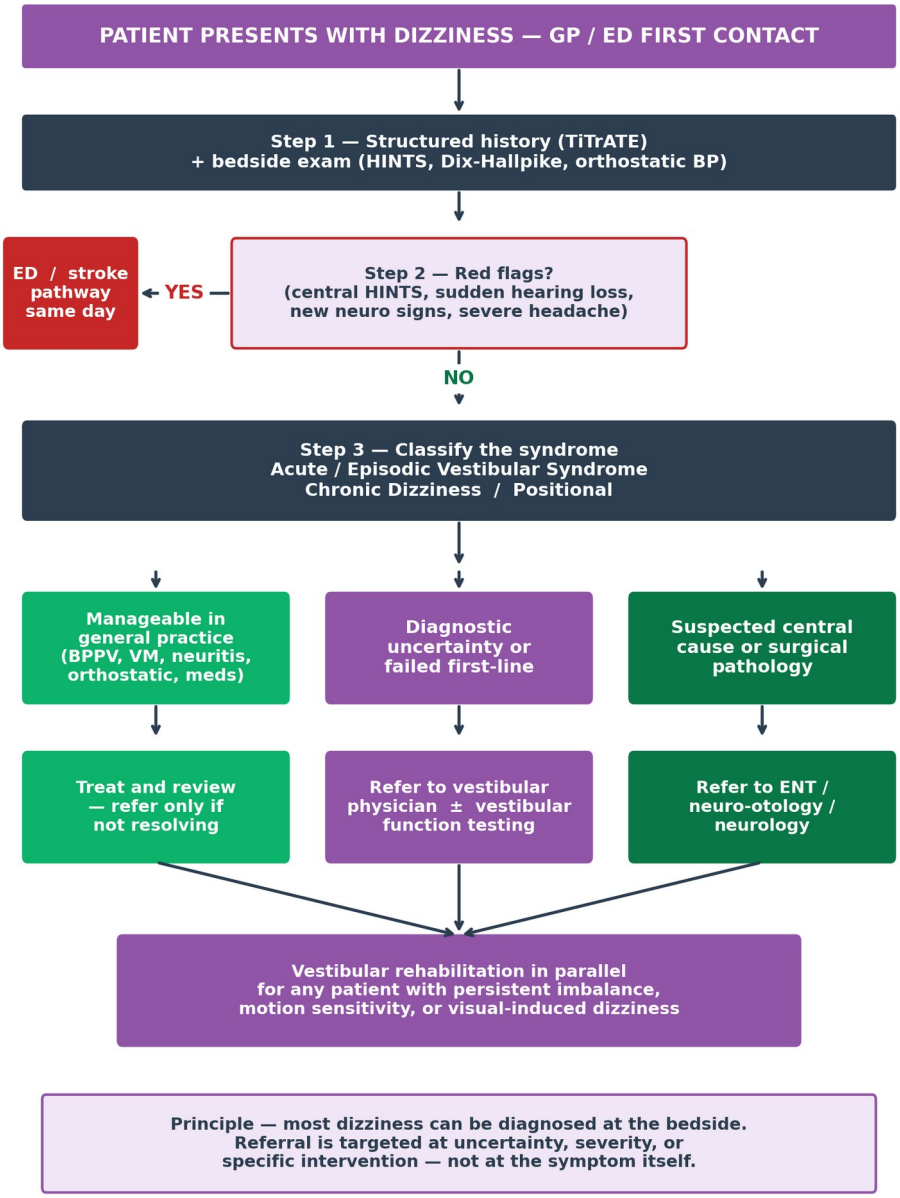

Figure 1. First-contact triage pathway for the dizzy patient — most cases are diagnosable at the bedside; referral is targeted at uncertainty, severity, or specific intervention.

Source: Australian Dizziness Clinics — clinical flowchart.

II. The Australian Vestibular Workforce

No single specialty owns vestibular medicine in Australia. Patients move through a heterogeneous mix of providers, each with different strengths, waitlists, and Medicare arrangements. Understanding what each provider does — and does not do — is the prerequisite for sending a referral to the right person.

Table 1 — The Australian Vestibular Workforce

Provider	Strengths	Limitations
General practitioner	First contact; bedside diagnosis; manages BPPV, VM, neuritis, orthostatic dizziness; safety-nets	Limited time; variable training in bedside vestibular exam
Vestibular physiotherapist	BPPV manoeuvres; vestibular rehab; gaze stabilisation; balance retraining	Cannot prescribe; does not perform formal vestibular function testing

Provider	Strengths	Limitations
Vestibular physician (GP-SI)	Dedicated vestibular consult; bedside testing; medication initiation; coordinates rehab and imaging	New model; limited number nationally. Australian Dizziness Clinics aims to expand to provide more services nationally through education and streamlining of referral pathways.
Audiologist	Audiometry; tympanometry; selected VEMP and vHIT testing; hearing aid fitting	Cannot make medical diagnosis; testing requires medical interpretation
ENT / otologist	Surgical management (Meniere, SCDS, schwannoma, fistula); intratympanic therapy; combined ear and balance	Long waits in public system; non-surgical chronic dizziness often deferred
Neuro-otologist	Combined neurological and otological diagnosis; complex central + peripheral cases	Very small workforce; concentrated in major centres
Neurologist	Stroke, MS, episodic ataxia, complex migraine; central vestibular disorders	Generalist neurologists may have limited vestibular interest
Geriatrician / falls service	Multifactorial dizziness in older adults; medication review; falls prevention	May not perform vestibular bedside exam

No single provider can manage every dizzy patient. Effective referral matches the syndrome to the available skill-set.

□ **Clinical Insight:** In practical terms, the rate-limiting step is rarely the absence of a provider — it is the choice of provider. A patient with vestibular migraine sent to ENT will wait six months for a normal audiogram; the same patient sent to a vestibular physician or neurologist with an interest in vestibular medicine can be diagnosed and started on prophylaxis at the first appointment.

The Vestibular Physician Model

Internationally, comparable services exist in different forms — the German Center for Vertigo and Balance Disorders in Munich is a consultant-led tertiary academic centre integrating neurology, ENT, and neuroradiology [5], and the United Kingdom has Audiovestibular Medicine as a recognised consultant medical specialty supported by audiologist-led testing pathways [6]. The GP-with-special-interest vestibular physician model is a distinctively Australian primary-care extension that brings integrated vestibular assessment closer to the patient and reduces dependence on oversubscribed tertiary services.

III. Conditions GPs Can Manage Without Referral

Approximately 60 to 70 percent of all vestibular presentations seen in general practice can be diagnosed at the bedside and managed in the community using the structured approach laid out in LR01 to LR13 of this series [7].

Benign Paroxysmal Positional Vertigo

BPPV is diagnosed at the bedside with the Dix-Hallpike test (posterior canal) or supine roll test (horizontal canal). It is treated with a single Epley or Semont manoeuvre (posterior canal) or Lempert / Gufoni manoeuvre (horizontal canal). A single manoeuvre resolves symptoms in 60 to 80 percent of patients, and a second within two weeks resolves a further 20 percent [8]. The GP should refer only after two failed manoeuvres, or where the diagnosis is uncertain (atypical nystagmus, central features, or persistent vertigo between attacks).

Vestibular Migraine

Vestibular migraine is the commonest cause of recurrent vertigo not due to BPPV. Diagnosis follows the Bárány Society and International Headache Society 2012 criteria — recurrent vestibular symptoms, a history of migraine, and a temporal relationship between vertigo and migraine features in at least 50

percent of episodes [9]. First-line management — lifestyle modification (the SEEDS framework: sleep, exercise, eat, diary, stress), trigger identification, and a 3-month trial of a first-line preventer such as propranolol, amitriptyline, or candesartan — sits firmly within GP scope. Refer only if symptoms persist after two adequate prophylactic trials.

Vestibular Neuritis

Vestibular neuritis presents as the dominant differential of acute vestibular syndrome alongside posterior circulation stroke. Once central features have been excluded by HINTS, neuritis is a clinical diagnosis. Symptomatic management with vestibular suppressants for the first 48 hours (then weaning rapidly) and early initiation of vestibular rehabilitation deliver excellent recovery in the majority of patients [10]. Referral is required only if recovery is delayed beyond 4 to 6 weeks, or if hearing loss develops (suggesting labyrinthitis or schwannoma).

Orthostatic and Medication-Related Dizziness

Orthostatic intolerance and medication-induced dizziness are diagnosed by history plus a properly performed lying-and-standing blood pressure measurement. A medication review and structured non-pharmacological advice (gradual postural change, hydration, compression, exercise) should always precede any expert referral. The diagnostic yield from autonomic testing in straightforward cases is low and the wait is long [11].

□ **Clinical Pearl:** The bedside vestibular examination — HINTS, Dix-Hallpike, head impulse, gait — takes under five minutes and resolves the diagnostic question in most dizzy patients. Building this five-minute examination into the consultation is the highest-yield single change a GP can make.

Figure 2. Specialty selection — match the syndrome to the provider, not the symptom.
Source: Australian Dizziness Clinics — clinical flowchart.

IV. Acute Red Flag Pathway — Same-Day Escalation

A small but critical subset of dizzy patients require same-day escalation. Missing them costs lives or hearing. The five red-flag presentations below should trigger an immediate phone call to the receiving service rather than a written letter and outpatient triage.

Acute Vestibular Syndrome with Central HINTS

A patient with acute, continuous vertigo lasting more than 24 hours and any one of (i) a normal head impulse test, (ii) direction-changing or vertical nystagmus, or (iii) skew deviation, has central HINTS and posterior circulation stroke must be presumed. HINTS in skilled hands is more sensitive than early MRI-DWI for posterior circulation stroke (sensitivity 100 percent versus 80 to 88 percent in the first 48 hours) [12]. The pathway is the local stroke pathway — not an outpatient ENT or neurology letter.

Sudden Sensorineural Hearing Loss with Vertigo

Covered in detail in LR11. SSNHL with vertigo is an otological emergency. Oral high-dose corticosteroid (prednisolone 1 mg/kg/day, max 60 mg, for 7 days then taper) should be commenced within 72 hours, and urgent ENT, audiology, and MRI IAM arranged. Where vertigo is prominent, AICA stroke must also be excluded.

Suspected Vertebral Artery Dissection

New severe occipital headache or posterior neck pain accompanying acute vertigo, particularly in a younger patient or following neck trauma or chiropractic manipulation, mandates same-day CT angiography or MRA. Vertebral artery dissection is the commonest cause of posterior circulation stroke in patients under 45 [13].

Bacterial Labyrinthitis or Meningitis

Vertigo with fever, headache, meningism, or signs of systemic sepsis requires emergency department transfer for lumbar puncture and intravenous antibiotics. The hearing loss in bacterial labyrinthitis becomes irreversible within hours.

Acute Vertigo Following Head or Neck Trauma

New vertigo within 24 hours of a head or neck injury raises concern for labyrinthine concussion, perilymph fistula, vertebral artery dissection, or post-traumatic central injury. Imaging (CT brain, CT angiography, MRI as indicated) and same-day expert input are required.

□ **Important:** Tier 1 referrals — same-day escalation — must be conveyed by phone. A written letter alone is inadequate, regardless of how clearly worded it is. Always document the name and time of the receiving clinician you spoke with.

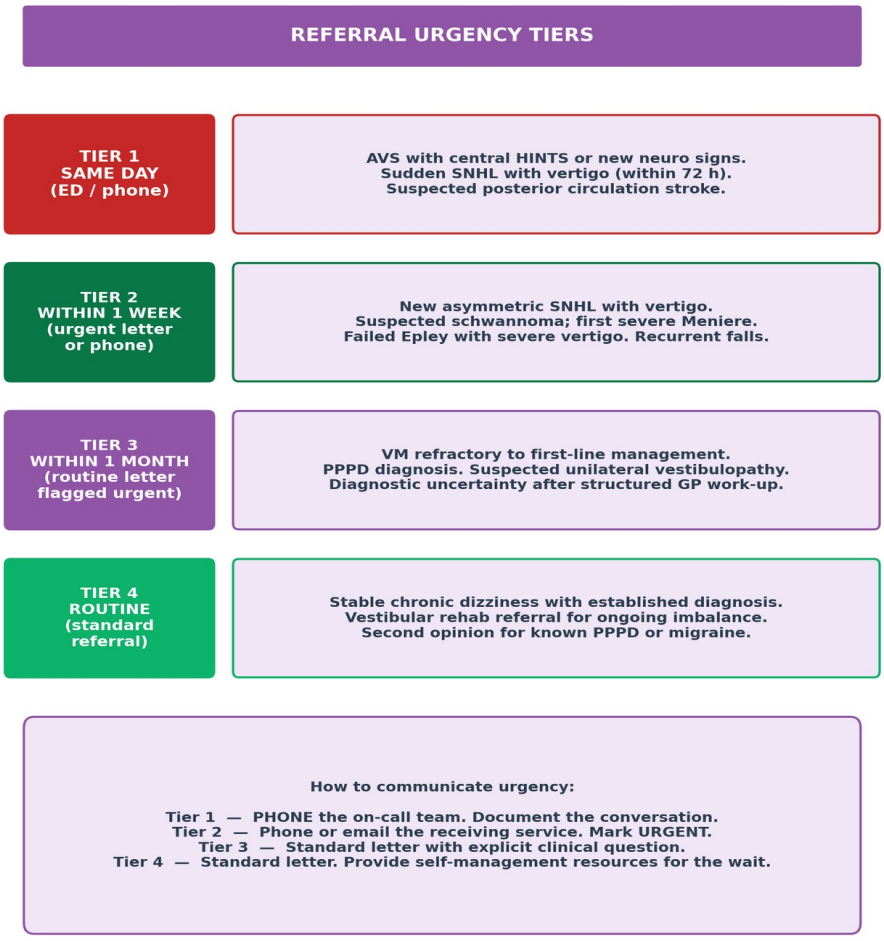

Figure 3. Referral urgency tiers — match how quickly the patient needs to be seen to how the referral is communicated.

Source: Australian Dizziness Clinics — clinical flowchart.

V. Subacute Pathway — Vestibular Function Testing

Where the bedside diagnosis is uncertain or where targeted intervention requires confirmation of a peripheral lesion, vestibular function testing (VFT) is the next step. VFT is not a routine first-line investigation — its diagnostic yield in unselected dizziness is low and the test battery is expensive in time and money. Referred well, it is high-yield. Referred poorly, it confuses the picture.

Indications for Vestibular Function Testing

- Persistent imbalance after an acute vestibular event suggesting incomplete central compensation, where vHIT and caloric testing quantify the residual deficit and direct rehabilitation.
- Suspected unilateral vestibulopathy in a patient with chronic motion sensitivity or oscillopsia, where caloric asymmetry or vHIT VOR gain reduction confirms the diagnosis.
- Suspected superior canal dehiscence syndrome — cVEMP threshold and amplitude testing is diagnostic.
- Pre-operative work-up for ENT procedures (cochlear implant, labyrinthectomy, vestibular nerve section).
- Medico-legal documentation of vestibular function in motor vehicle accident, workers compensation, or DVA cases.

Where to Send the Patient

In Australia, comprehensive vestibular function testing (videonystagmography, caloric, rotational chair, vHIT, VEMP, posturography) is offered by a small number of dedicated vestibular laboratories — typically attached to ENT or audiology services. The Australian Dizziness Clinics network offers VFT as part of an integrated vestibular consult. Audiology private practices with vestibular interest (most state capitals) will also perform selected VFT components, but the medical interpretation must be done by a referring vestibular physician, neurologist, or otolaryngologist.

□ **Clinical Insight:** Order VFT to answer a specific clinical question. A blanket referral for "vestibular testing" frequently produces a battery of results that is interpreted in isolation, with no link back to the clinical question. Always flag what you want to know — for example, "Is the right vestibular function reduced?" — in the referral letter.

VI. The Vestibular Physician — A New Pathway

The vestibular physician model — a GP with vestibular training providing a dedicated diagnostic consult — has emerged as a practical solution to the bottleneck in vestibular care. The model exists to absorb the volume of patients for whom a tertiary expert consult is unnecessary but bedside primary-care diagnosis has not resolved the question. It does not replace ENT, neuro-otology, or neurology — it complements them.

Best-Fit Referrals to a Vestibular Physician

- Diagnostic uncertainty after structured GP work-up — patient has been seen, examined, and partially worked up but the syndrome does not fit cleanly into a single category.
- Failed first-line management of BPPV (after two manoeuvres), vestibular migraine (after two prophylactic trials), or vestibular neuritis (recovery delayed past six weeks).
- Suspected PPPD requiring confirmation of diagnosis, exclusion of unrecognised peripheral lesion, and structured rehabilitation plan.
- Recurrent unexplained falls in a community-dwelling adult where multifactorial dizziness is suspected and a vestibular contribution must be quantified.
- Patient request for a one-stop comprehensive vestibular review — particularly where work, driving, or insurance disability claims depend on a clear diagnosis.

When NOT to Refer to a Vestibular Physician

- Acute red-flag presentations — these require ED or stroke pathway, not a vestibular physician.
- Pure hearing loss without vestibular features — refer to ENT or audiology.

VII. ENT, Neuro-otology, and Surgical Referral

ENT and neuro-otology referral is targeted at patients with structural otological disease, surgical management options, or combined hearing and vestibular pathology that requires both medical and surgical input.

Clear Indications for ENT or Neuro-otology Referral

- For intratympanic gentamicin and steroid injection or other surgical management of refractory cases of Ménière's disease where conservative management with pharmacological agents has failed.
- Vestibular schwannoma identified on MRI — for combined neurosurgical and otological assessment.
- Superior canal dehiscence syndrome with disabling sound-induced or pressure-induced vertigo — for consideration of canal plugging and resurfacing when history matches SCD and VEMP and radiological testing confirm the diagnosis. The work-up before referral can be done by a vestibular physician or neuro-otologist.
- Perilymph fistula — particularly post-traumatic — for surgical exploration if conservative management fails.
- Otosclerosis with vertigo — for stapedectomy assessment.
- Chronic otitis media or cholesteatoma with associated vestibular symptoms.
- Conductive or mixed hearing loss alongside vertigo — addressing the conductive component is the otologist's domain.

Public versus Private — A Practical Note

Public ENT outpatient categorisation in most Australian states puts non-urgent vestibular dizziness (no hearing loss, no surgical question) at Category 3 with waits of 6 to 12 months. The patient is often best served by either (i) a private ENT consult if affordable, (ii) a vestibular physician consult to clarify the diagnostic question, or (iii) a written escalation to the public service if the working diagnosis is surgical Meniere, schwannoma, or SCDS.

VIII. Neurology Referral

Neurology referral is reserved for patients in whom a central nervous system disease is suspected or proven, or where the vestibular syndrome is one component of a broader neurological picture.

Clear Indications for Neurology Referral

- Suspected demyelinating disease — recurrent vertigo with optic neuritis, sensory disturbance, or other dispersed neurological features in a young adult.
- Episodic ataxia (Type 1 or Type 2) — childhood- or early-adult-onset recurrent ataxia with vertigo, family history positive.
- Cerebellar disease — progressive ataxia, dysarthria, gaze-evoked nystagmus, or cerebellar atrophy on imaging.
- Stroke beyond the acute window — for risk-factor management, secondary prevention, and rehabilitation planning.
- Atypical migraine presentations — basilar-type migraine, recurrent vertigo with neurological aura, hemiplegic migraine.
- Suspected functional neurological disorder where vestibular symptoms are one part of the broader picture.

□ **Clinical Insight:** Vestibular migraine, although a migraine variant, is most often best managed by a vestibular physician or a neurologist with specific vestibular interest — not by a generalist neurologist whose practice does not include vestibular disorders. Where possible, ask the patient or the receiving service whether a vestibular interest is held within the rooms.

IX. Writing an Effective Referral Letter

The letter is read for clinical question first, urgency second, and detail third. Letters that bury the question inside the narrative are routinely under-categorised.

The Eight Components of a Good Vestibular Referral

- Clinical question — diagnosis, intervention, second opinion, or testing? One sentence. State this first.
- Symptom timing using the TiTrATE framework — Timing (acute / episodic / chronic), Triggers, Targeted exam findings. Include episode duration and date of first episode.
- Hearing and otological features — laterality of hearing change, tinnitus, aural fullness, otoscopy. Attach a recent audiogram if available.
- Bedside examination findings — HINTS components, Dix-Hallpike result, head impulse, gait, orthostatic BP, nystagmus pattern.
- Differential considered — the working diagnosis and the next-most-likely alternatives. Demonstrates the framework you have applied.
- Trials and investigations to date — Epley attempts, prophylactic trials, medication changes, MRI / audiogram / blood results. Attach copies.
- Functional impact — driving, work, falls, mood, anxiety pattern. This drives triage urgency more than the symptom itself.
- Patient expectations — what the patient hopes to gain from the referral, willingness to travel, telehealth acceptability, insurance / DVA / MVA cover.

□ **Key Point:** Three sentences a triage clinician needs to find quickly: (i) what is the problem; (ii) what have you tried; (iii) what do you want from me. If your letter does not answer those three questions in the first paragraph, rewrite the first paragraph.

Closing the Loop

The referral pathway is incomplete without follow-up. The GP should book a review at four to six weeks regardless of the receiving clinician's expected wait, both to safety-net the diagnosis and to manage the patient through the referral period. Particular attention must be given to driving advice, falls risk, and mood — all of which deteriorate measurably during long waits for vestibular care [14].

Figure 4. Anatomy of an effective vestibular referral letter — eight components that turn a list of symptoms into a structured clinical question.

Source: Australian Dizziness Clinics — clinical flowchart.

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