Cold Caloric Test Template

Patient Information:

Patient Name:___________________________________Date of Birth:_____________

Medical Record Number:__________________________Date of Test:______________

Healthcare Practitioner: ___________________________

Clinical History:

- **Chief Complaint:**
- **Relevant Medical History:**
- **Medications:**
- **Allergies:**

Procedure Details:

- **Date of Test:**
- **Practitioner's Name:**
- **Facility:**
- **Indication for the Test:**
- **Pre-test Instructions Given:**

Test Parameters:

- **Baseline Nystagmus (if any):**
- **Ear to be Tested (Right/Left):**
- **Temperature of Cold Water/Air (°C):**

Test Procedure:

1. **Explain the procedure to the patient:**
2. **Inspect the ear canal:**
3. **Record baseline nystagmus:**
4. **Administer cold water into the ear canal:**
    - Amount:
    - Duration:
    - Temperature:

5. **Observe and record nystagmus response:**
    - Direction:
    - Onset:
    - Duration:
    - Intensity:

Interpretation:

- **Normal Response:**
- **Abnormal Findings:**
- **Further Recommendations:**

Post-Test Instructions:

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Follow-Up Plan:

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*Practitioner's Signature:*______________________________ *Date:* ________________

Patient's Signature (if applicable): _____________________ *Date:* ________________