

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:* _____