EEG REQUISITION

ELECTROENCEPHALOGRAM

Joseph Brant Memorial Hospital
Medical Diagnostic Unit
Phone: 905-336-4104 ◆ Fax: 905-681-4805

An appointment must be made in advance with the Medical Diagnostic Unit.

APPOINTMENT DATE: ____________ **TIME:** __________

Referring Physician: ______________________________

Send Copies To: ______________________________

Patient Name**:** ______________________________

Address: ______________________________

City: ________________ Postal Code: ____________

D.O.B: ______________
DD MM YYYY

Home Phone: ____________ Mobile Phone: ____________

Health #: ____________________ VERSION: ________

☐ **BOOK AS OUT PATIENT**

Doctors' office staff:
Please inform your patient of this booked appointment.

PHYSICIAN TO COMPLETE ALL DETAILS

Clinical Diagnosis: ______________________________

Summary of History and Physical Examination*:* ______________________________

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Anti-Convulsant medication*:* ______________________________

Other Medications*:* ______________________________

Previous EEG Test: **Yes:** ☐ **No:** ☐ **Where:** ______________________________

PLEASE CHECK REQUIRED TEST

ROUTINE EEG, AWAKE, ☐

SLEEP DEPRIVED, With VIDEO ☐

SLEEP DEPRIVED, No VIDEO ☐

***** Patient to have clean scalp, free of hair product. No braids, hair pieces, etc.*****

ALL REQUISITIONS SHOULD BE COMPLETED IN FULL & SENT TO:

THE MEDICAL DIAGNOSTIC UNIT

MAIN FLOOR - BETWEEN EMERGENCY AND CANCER CLINIC

______________________ ____________
Physician's Signature Date

71970(REVJan-2012)