EEG REQUISITION

ELECTROENCEPHALOGRAM

Joseph Brant Memorial Hospital
Medical Diagnostic Unit
Phone: 905-336-4126 ◆ Fax: 905-681-4805

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: _____

☐ **OUTPATIENT**

☐ **INPATIENT**

PHYSICIAN TO COMPLETE ALL DETAILS

Clinical Diagnosis: _____

Summary of History and Physical Examination*:* _____

_____

Anti-Convulsant medication*:* _____

Other Medications*:* _____

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

PLEASE CHECK REQUIRED TEST

ROUTINE EEG, AWAKE ☐

SLEEP DEPRIVED EEG ☐

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

_____ _____
Physician's Signature Date