Halton Healthcare
GEORGETOWN · MILTON · OAKVILLE

Neurophysiology Dept.

E.E.G. REQUISITION

(Electroencephalogram)

FAX completed and signed requisition to 905-338-4494 – Neurophysiology Department

This form MUST be completed and signed by Referring Physician PRIOR TO TEST.

❒ Out-Patient ❒ In-Patient - Ward: _____

❒ Routine E.E.G with Video Monitoring

❒ Sleep Deprived E.E.G.

❒ Previous E.E.G

Location Where Done: _____

Results: _____

MEDICATION(S): _____

_____

_____

_____

Patient Name: _____

Unit #: _____

APPT. DATE _____

Address: _____

_____

May we contact patient to confirm appt?
❒ Yes ❒ No

Phone (H): _____

Phone (W): _____

Phone (C): _____

Date of Birth: _____

Health Card #: _____

HISTORY and PHYSICAL FINDINGS: (seizures, age at onset, pattern, frequency, blackouts, LOC, date of head injury, surgery, strokes, etc.)

_____

_____

_____

_____

_____

_____

_____

Clinical Diagnosis: _____

Physician - Signature: _____

Physician - Print Name: _____

E.E.G.#: _____

E.E.G Date Performed: _____

Print or Stamp – MUST BE FILLED OUT

Physician Name: _____

Address: _____

Phone No. _____

Fax No. _____

H2322