EEG Patient Request Form

Queensland Neurology Services

www.qldneurologyservices.com.au

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Patient Details:

Surname: .... First Name: ....

DOB: .... Email: ....

Address: ....

Home Ph: .... Work: .... Mobile: ....

Clinical History: ....

....

....

Age of first seizure: .... Family history of Epilepsy: ....

Semiology of the seizures: ....

Has the pt had an EEG?: .... Has the pt had an MRI scan? .... Urgency: ....

Investigation:

- ☐ Routine EEG
- ☐ Sleep-deprived EEG
- ☐ Inpatient EEG
- ☐ ICU EEG

Referring Doctor Details:

Doctors Name: ....

Address: ....

....

Signature: .... Provider No: ....

Date of Referral: ....Email: .... Fax: ....

Copy of Report to: ....