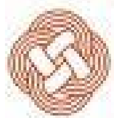

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EEG Requisition

We Accept Patients 6 years and Older

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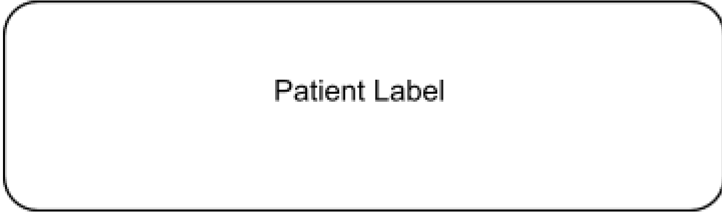
Address:______________________________ Sex: M ☐ F ☐

______________________________ Health Card # & VC____________________

Telephone (Home)____________________

(Cell)____________________



Please check off which test below:

- ❑ **Routine**
- ❑ **Sleep-Deprived (SD)**
- ❑ **Ambulatory EEG (24 to 96 hours continuous EEG)**
- ❑ **Longer Recording (Please circle how long) 60 Min 120 Min 180 Min**

Brief Clinical Info. ____

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____

____

Medication ____

____

☐ See Attached Medication List

Ordering Physician:______________________________ **Billing #:** ____________________

(Please Print) **Fax # :**____________________

Date:____________________ Signature:______________________________

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