TELE-N-CEPHALON
Re-Inventing Health Care Delivery

EEG Requisition

www.Neuro-Diagnostics.ca

Phone: 437-291-0456

Fax: 1-855-739-0003

Name:_____DOB (dd/mm/yyyy)__ _____

Address:_____Sex: M ☐ F ☐

_____ Health Card # & VC_____

Telephone (Home)_____

(Cell)_____

Patient Label

Please check off which test below:

❑ **Routine** ☐ **In-Patient Hospital Name Floor ext. Number:**_____

❑ **Sleep-deprived (SD)**

❑ ***Ambulatory EEG (24 to 48 hours continuous EEG): Please attach the Consent form from https://www.neuro-diagnostics.ca/patient-area**

❑ **Longer Recording (Please circle how long) 60 Min 120 Min 180 Min**

Brief Clinical Info. _____

_____

_____

_____

Medication _____

Ordering Physician:_____**Billing #:** _____

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

Date:_____Signature:_____

Report Copies To:_____

(Please Print|)

10594 Yonge St, **Richmond Hill (Richmond Hill Medical Mall)**
170 Colborne St W, **Orillia (Orillia Soldiers' Memorial Hospital)**
459 George Street N **Peterborough (Be Well Centre)**
2863 Ellesmere Road, Unit 406, **Scarborough (SHN-Centenary site)**
52 Cannon Street Unit 103, **Hamilton (Hamilton Medical Centre)**
300 Rossland Road E, Unit 301**, Ajax**
61 Dover Street, **Chatham**
965 Bovaird Dr W, Unit 19, **Brampton**

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