BC CHILDREN'S HOSPITAL
An Agency of the Provincial Health Services Authority

DEPARTMENT OF DIAGNOSTIC NEUROPHYSIOLOGY
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www.bcchildrens.ca

REQUISITION FOR EEG

(To be completed fully and legibly by referring physician)

NAME:
DOB:
GENDER: M / F
HOSPITAL #:
PHN:
ADDRESS:

PHONE NUMBER(S):

ISOLATION: RESPIRATORY / ENTERIC / MRSA
TRANSLATOR: N / Y Language: _____

ALL PATIENTS MUST BE SLEEP DEPRIVED FOR THIS TEST UNLESS OTHERWISE INDICATED
(For more information visit Clinical, Family & Diagnostic Services at www.bcchildrens.ca)

REASON FOR EEG (CHECK AS MANY AS APPLY)

TO DETERMINE:

- ❑ IF EVENT(S) ARE SEIZURES *
- ❑ SEIZURE TYPE *
- ❑ EPILEPSY SYNDROME
- ❑ ? SUBCLINICAL SEIZURES *
- ❑ ? NON-CONVULSIVE STATUS *
- ❑ NEW SEIZURE TYPE *

TO EVALUATE:

- ❑ SEIZURE CONTROL FOLLOW-UP
- ❑ CHANGE IN MEDICATION
- ❑ RECURRENCE OR INCREASE IN SEIZURES

OTHER:

- ❑ REPEAT EEG FOR SLEEP
- ❑ TO CAPTURE AN EVENT *
- ❑ DECREASED LOC – CAUSE UNDETERMINED
- ❑ ? ENCEPHALOPATHIC
- ❑ OTHER (please indicate) *

*** BRIEF DESCRIPTION OF SEIZURE(S)/EVENT(S) IN QUESTION:**

_____

_____

AUTISM/AUTISTIC SPECTRUM DISORDER: N / Y Additional information: _____

PAST MEDICAL HISTORY: _____

CURRENT MEDICATION(S): _____

ARE YOU LOOKING FOR ANYTHING SPECIFIC: ☐ NO ☐ YES IF YES, SPECIFY: _____

ANY PROCEDURE(S) CONTRAINDICATED: ☐ NO ☐ YES IF YES, SPECIFY: _____

PREVIOUS EEGS (DATE): _____ WHERE PERFORMED: _____

SEDATION REQUIRED: ○ NO ○ YES (all sedation patients must be sleep deprived)

- If yes, **Dexmedetomidine** intranasal (3 mcg/kg & 1 mcg/kg PRN up to a maximum of 200 mcg/dose) will be given.
- Please note that at BC Children's Hospital Diagnostic Neurophysiology Department, Sedated EEG requests are accepted only from Pediatric Neurologists.

☐ I have received consent from patient/parent and documented it in the chart**

SIGNATURE OF REFERRING PHYSICIAN: _____ M.D.

MSP Billing #: _____

SEND REPORTS TO: _____