



An agency of the Provincial Health Services Authority

Department Of Diagnostic Neurophysiology
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REQUISITION FOR EVOKED POTENTIALS

(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: _____

REASON FOR EVOKED POTENTIAL TESTING: _____

PROCEDURE(S) REQUESTED:

BRAINSTEM AUDITORY EVOKED POTENTIALS

(Neurodiagnostic - not for hearing assessment)

Normal external canals / ear drums? YES / NO

VISUAL EVOKED POTENTIALS

(Corrective lenses must be worn. Flash stimulation will be used if patient is unable to fixate on an image for a prolonged time period.)

Visual acuity: Right eye ____ / ____ Left eye ____ / ____

VISUAL EVOKED POTENTIALS (For cortical assessment - not for optic nerve assessment)

CVI [] Ocular albinism []

SOMATOSENSORY EVOKED POTENTIALS

Upper limbs [] Lower limbs []

BRIEF SUMMARY OF PRESENTING COMPLAINTS: _____

Are you looking for anything specific? If yes, please specify: _____

SEDATION: For brainstem auditory and somatosensory evoked potentials Chloral Hydrate (30-50 mg/kg to a maximum of 1500 mg) may be given unless indicated below:

- No sedation should be given.
Alternate sedation (prescription and administration must be arranged by the referring physician).

SIGNATURE OF REFERRING PHYSICIAN: _____ M.D.

MSP Billing No.: _____

SEND REPORTS TO: _____