



DEPARTMENT OF DIAGNOSTIC NEUROPHYSIOLOGY
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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: _____

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)

- Appointments for patients requiring sedation are available on selected days.
- Chloral Hydrate (30-50 mg/kg to a maximum of 1500 mg) will be given unless indicated below.

ALTERNATE SEDATION: NO YES (Prescription and administration must be arranged by the referring physician.)

SIGNATURE OF REFERRING PHYSICIAN: _____ M.D.

MSP Billing #: _____

SEND REPORTS TO: _____