Dr Sekhar Pillai
Paediatric Neurologist, Paediatrician
SYDNEY PAEDIATRIC NEUROLOGY

Sydney Paediatric Neurology & EEG
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EEG (Electroencephalogram) Request Form

*The information is private and **confidential.***

Test Required

❑ Standard EEG ❑ Overnight Video EEG & Clinical Review

Patient Information

Full name: ______________________________________ D.O.B: ____/____/_______

Address: ____

Parent/Guardian Name: ________________________________ Mobile: ______________________________

Email address:____

Clinical Information
Questions to be answered by the EEG:

Clinical Information:

Description of Seizure/Event:

Medication:

Previous EEG: ❑ Yes ❑ No
Report:
Location

Previous MRI/CT Head result: ❑ Yes ❑ No
Report:
Location:

Referring Doctor's Details

Name: Dr_______________________________ Provider No.: _____________________________

Address:____

Fax: ________________________Email____

Signature: ___________________________ Date: ____/____/_______