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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 ❑ Sleep Deprived 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:

- Frequency of seizure/event: _____
- Date of the last seizure/event:_____
- Medication (name/dosage): _____

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: ____/____/_____