Kingston General Hospital

COMPLETE ALL INFORMATION IN DARK OUTLINE AREA

APPOINTMENT DATE AND TIME

_____

REFERRED BY

DR. _____

REPORT COPIES TO:

DR. _____

DR. _____

_____

_____

_____

EEG#

EEG ☐

SLEEP DEPRIVED EEG ☐

AMBULATORY EEG* ☐

cEEG (ICU ONLY) ☐

EVOKED POTENTIALS

VISUAL ☐

SOMATOSENSORY

MEDIAN ☐

POSTERIOR TIBIAL ☐

OTHER ☐

_____

_____

CR # _____ HEALTH # _____

SURNAME _____ GIVEN _____

ADDRESS _____

CITY _____ POSTAL CODE _____

DATE OF BIRTH _____/_____/_____
YEAR MONTH DAY

TEL HOME _____ BUSINESS _____

AGE	SEX	LOCATION IN ☐ OUT ☐

DATE & TIME RECORDED **YEAR** / **MONTH** / **DAY** A.M. ☐ P.M. ☐

MEDICATIONS

PATIENT HISTORY

NEUROLOGICAL & PSYCHIATRIC SIGNS

CLINICAL DIAGNOSIS

TYPE OF INFORMATION SOUGHT

HYPERVENTILATION AND PHOTIC STIMULATION ARE DONE AS A ROUTINE. FOR SPECIAL TECHNIQUES, CONTACT TECHNOLOGISTS.

*Please consult the EEG Department prior to referring a patient for Ambulatory Monitoring.

KINGSTON GENERAL HOSPITAL
CONNELL 7 RM 2 - 706
TEL: 613 548-7835
FAX: 613-548-2451

_____
PHYSICIAN'S SIGNATURE

_____
REQUEST MADE (yyyy/mm/dd)

Please call to schedule appointment before faxing requisition.

CLINICAL NEUROPHYSIOLOGY REQUISITION

KGH Stores # 90630/2013/10 2016/12