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. ☐

MEDICATION

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

http://www.kgh.on.ca/sites/default/files/eeg requisition.pdf

PHYSICIAN'S SIGNATURE

DATE REQUEST MADE (YYYY/MM/DD)

CLINICAL NEUROPHYSIOLOGY REQUISTION

KGH Stores # 90630/2013/10