Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

8611

Electroencephalography EEG REFERRAL

Department of Neurology, EEG services
KGH Connell 7 Rm 2-706
Tel: 613 548-7835
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PATIENT INFORMATION

Name: _____

DOB (yyyy/mm/dd): _____

HC #: _____ MRN: _____

Telephone: _____

Address: _____

_____

Service requested:

☐ EEG with Video
☐ Sleep Deprived EEG
☐ Ambulatory EEG (24 or 48 hr) please consult the EEG Dept. prior to referring for Ambulatory Monitoring
☐ Continuous EEG (cEEG)

EVOKED POTENTIALS: ☐ Visual ☐ Median somatosensory ☐ Posterior tibial somatosensory

Reason for Referral:

☐ First Seizure ☐ Suspected Seizures ☐ Known Epilepsy
☐ Cognitive/behavioural changes ☐ Altered mental status/encephalopathy ☐ CNS infection
☐ Traumatic Brain Injury ☐ Psychiatric including Psychogenic Non-Epileptic Seizures (PNES)

☐ Other: _____

Patient History: _____

_____

Medications: _____

_____

Referring Health Practitioner Information *Please provide full name and sign the requisition*

Name: _____ Billing Number: _____

Phone: _____ Fax: _____

Physician's Signature: _____ Date (yyyy/mm/dd): _____

CLINICAL USE: Priority #_____ Prioritized by _____ EEG# _____

APPOINTMENT: Date (yyyy/mm/dd) _____ Time (hhmm) _____

KHSC Print Shop #290, 2025/12

Scan to: Referral – Neurology (EEG Requisition)