Sunnybrook
HEALTH SCIENCES CENTRE

Name:	
Address:	
Telephone:	D.O.B. / /
OHIP	
Hospital File No.	
Account #	
Appt. Date:	
Time:	
EEG#	
INPATIENT ☐	**OUTPATIENT** ☐

CLINICAL NEUROPHYSIOLOGY UNIT

EEG/EP REQUISITION

ROOM M1-600

TEL: (416) 480-4475
FAX: (416) 480-4674

☐ **MRSA +** ☐ **Respiratory Precautions**

☐ **Ambulatory** ☐ **Wheelchair** ☐ **Stretcher** ☐ **Ambulance Transfer**

Referring Physician:	**Physician Referral #:**
Phone Number:	**Fax Number:**

TYPE OF TEST REQUIRED:

EEG: ☐ **Routine** ☐ **Sleep Deprived** ☐ **3HR Prolonged EEG w/ Video**

EP: ☐ **Visual** ☐ **Auditory** ☐ **Somatosensory**

Medical History:

Does the patient have a cardiac arrhythmia? ☐ **YES** ☐ **NO**

Results of Neuroimaging:

Medications:

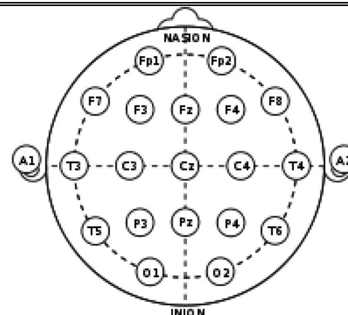
☐ **benzodiazepine or** ☐ **other sedative**

IF NEONATE:	**Referring Physician Signature**
GA: ___________wks ☐ **SVD** ☐ **CSec**	**Please Print Name:**
	Contact Number:

Instructions for **Sleep deprived & Prolonged EEG only:**

- **STAY AWAKE ALL NIGHT PRIOR TO EEG**
- If on medication, take as prescribed, unless instructed by physician
- No beverages containing caffeine
- Arrange driver to and from appointment

Please have clean hair with no products



Technologist use only

PR 30109
(2014/02/03)