Electroencephalogram (EEG) Requisition

Thank you for choosing Southern Ontario Epilepsy Clinic for your EEG needs . To best serve you within a reasonable time frame please have this form filled out completely and legibly so that it can be appropriately triaged by. Dr. Bercovici.

PLEASE FAX COMPLETED REFERRAL FORM TO **416-620-7633**

Patient Information

Name: ____ DOB: ___________________________

Health card number: ____________________________ Version Code: ___________________

Address: _______________________________________ City: ____________________________

Telephone #: Mobile: (_____)_______________ Home/Business: (_____)___________

Type for EEG (done with time locked video)

( ) Routine ( ) Sleep Deprived

( ) Prolonged video (Circle either 2 3 hour) ( ) 24 hour Ambulatory

Priority: ( ) Next available ( ) ASAP (please state reason) ____________________

Clinical history: ____

Medications: ____

Previous surgery:____

Allergies: ____

Referring Physician information

Name: _______________________________________ (MD / NP) Billing # __________________

Address: ____

Telephone # _________________________ Fax # ___________________________

Signature: _______________________________________

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