Lakeridge Health

AJAX/PICKERING
DEPARTMENT OF DIAGNOSTIC NEUROPHYSIOLOGY
580 HARWOOD AVE. SOUTH
AJAX, ONTARIO L1S 2J4
PHONE: 905−428−5217 (ext. 11684) / FAX: 905−428−5307

NAME:
DOB:
GENDER: M / F
MOBILE:
PHN:
ADDRESS:
OHIP #:
APPOINTMENT DATE AND TIME BELOW
DATE:
TIME:

REQUISITION FOR EEG

(To be completed fully and legibly by referring physician)

PLEASE CHECK INTENDED SERVICE

☐ **ROUTINE ELECTROENCEPHALOGRAPHY (EEG)**

☐ **SLEEP DEPRIVED ELECTROENCEPHALOGRAPHY (EEG)**

REASON FOR EEG (CHECK AS MANY AS APPLY)

TO DETERMINE

- ☐ IF EVENT(S) ARE SEIZURES *****
- ☐ SEIZURE TYPE *****
- ☐ EPILEPSY SYNDROME
- ☐ ? SUBCLINICAL SEIZURES *****

TO EVALUATE

- ☐ SEIZURE CONTROL FOLLOW−UP
- ☐ CHANGE IN MEDICATION
- ☐ RECURRENCE OR INCREASE IN SEIZURES

OTHER

- ☐ STROKE/TIA/TGA EVENT FOLLOW UP
- ☐ PRESYNCOPAL/SYNCOPAL
- ☐ ATHLETIC ASSOCIATION REQUIREMENT
- ☐ ? ENCEPHALOPATHIC

*** BRIEF DESCRIPTION OF EVENT(S) IN QUESTION:**

_____

_____

INTELLECTUAL DISABILITY/AUTISM/AUTISTIC SPECTRUM DISORDER: N / Y Additional information:

****SEDATION NOT OFFERED****

PATIENT LABEL

_____ M.D.
SIGNATURE OF REFERRING PHYSICIAN

_____ _____
PRINTED PHYSICIAN NAME CPSO #