St. Paul's Hospital
DEPARTMENT OF DIAGNOSTIC NEUROPHYSIOLOGY
Providence Building Room 2369 -
1081 Burrard Street, Vancouver, BC
Tel: 604-806-8650 Fax: 604-806-8624

EEG / EVOKED POTENTIALS REQUISITION

PATIENT INFORMATION (Print clearly)

Surname: _____

First: _____ **Middle:** _____

PHN: _____ **WSBC:** _____

DOB: _____ **Gender:** ☐ Male ☐ Female
(month/day/year)

Address: _____

City: _____ **Postal Code:** _____

Telephone Home: _____ Cell/Work: _____

☐ **URGENT** (within 2 weeks)

☐ **NON-URGENT**

Date of Referral: _____

Referring Dr: _____ MSP#: _____

Referring Dr FAX number: _____

Copies to: _____

Indicate Required Test ☑		
Electroencephalogram (EEG)		
	ROUTINE	
	SLEEP-DEPRIVED	
Evoked Potentials (EPs)		
VEP	Full-Field PATTERN	
	Hemi-field PATTERN	
	FLASH	
SEP	UPPER LIMB	
	LOWER LIMB	
BAEP		

HISTORY AND CLINICAL FINDINGS

_____

_____

_____

_____

Medication(s): _____

Patient's Special Needs (if any): _____

Allergies/Sensitivities: _____

Previous Study: (EEG / EP / imaging) _____

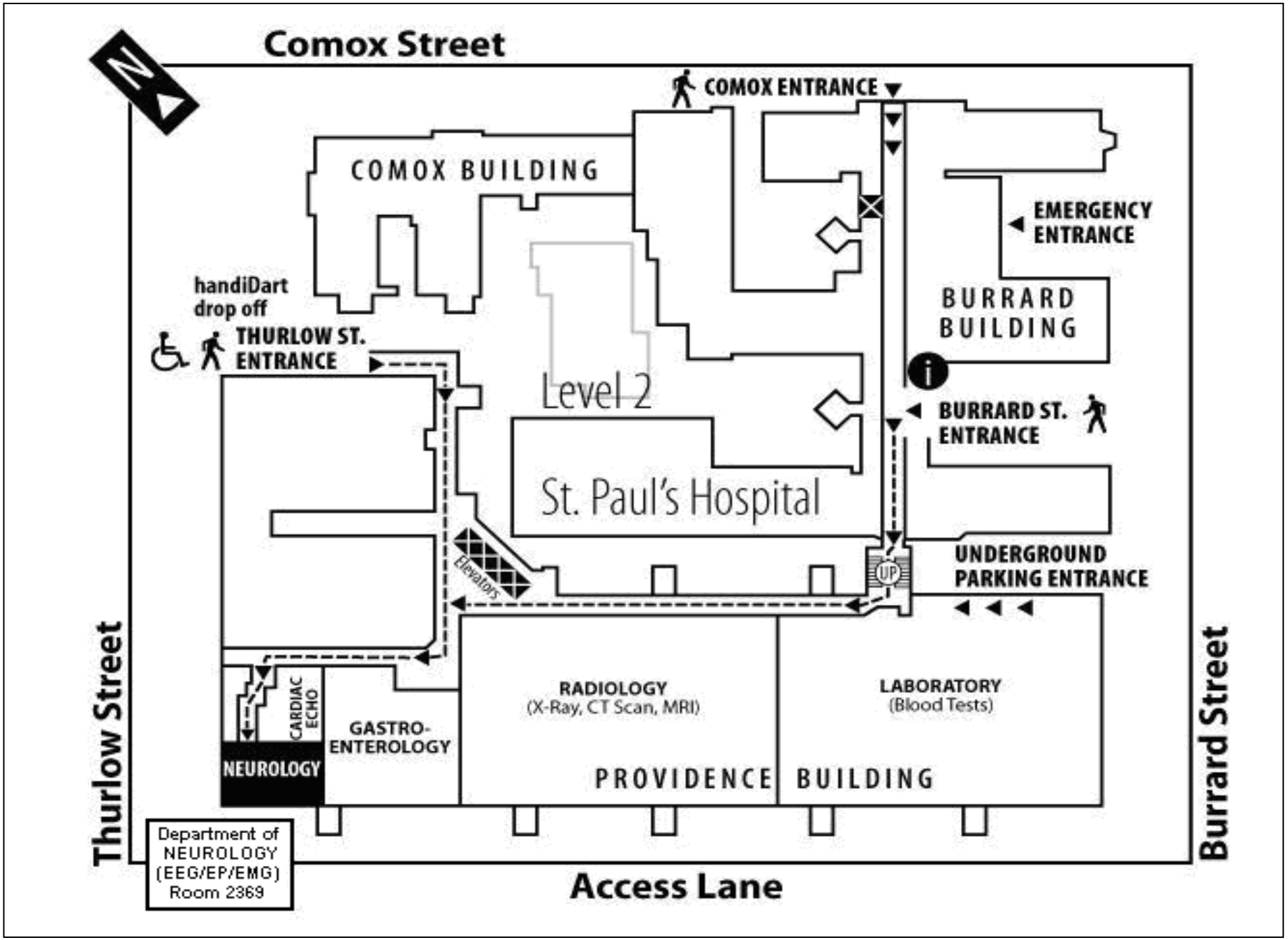
Physician's Signature: _____

OFFICE USE ONLY		
Date Requisition Received:	Interpreting Physician	Technologist
EEG / EP #		

APPOINTMENT BOOKING

Date: _____ Time: _____

Patient MUST confirm appointment <u>ONE WEEK IN ADVANCE</u> by calling 604-806-8650, or the appointment will be CANCELLED.



BACK

Form No. PHC-EE004 (R. Jun-11)