Clinical EEG (Electroencephalography) Request Form

Westmead Specialis
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35 Darcy Roa
WESTMEAD NSW 214
Ph: 02 9687 400
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info@westmeadspecialists.com.a
www.westmeadspecialists.com.a

Name:
D.O.B:
Sex
Address:

Phone:
Email:

Test Requested: Please tick ✓ (Please see information on website fore more details)

EEG: ❑Routine ❑Sleep-Deprived

Reason for Referral:

Relevant Clinical Summary:

Description of Seizure:

Frequency of Seizure: Daily/weekly/monthly/infrequent

Date of the last seizure

Triggers

Medication:

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Previous Investigations (If yes, date/location and result):
ECG

EEG

Scan MRI/ CT

Referring Doctor:
Address:

Provider Number:

Phone:

Fax

Email:

Date: