

**CHILDREN'S NEUROSCIENCE CENTRE  
WOMEN'S & CHILDREN'S HEALTHCARE NETWORK  
EEG/NEUROPHYSIOLOGY REQUEST**

6th Floor, Main Building, Royal Children's Hospital, Flemington Road, Parkville  
Ph: 9345 5661 Fax: 9345 5977

Surname: .....	UR: .....	<b>REQUEST FOR</b>
First Names: .....	DOB: .....	EEG <input type="checkbox"/>
Sex: .....		VEM <input type="checkbox"/>
Address: .....		NCS/EMG <input type="checkbox"/>
		SPINAL MON <input type="checkbox"/>
		SSEP <input type="checkbox"/>
Postcode: .....	Tel. No.: .....	ERG/VER <input type="checkbox"/>
		(Ophthalmology Ext. 5632)

Location: .....	Dr Requesting (Print): .....
	Address: .....
Date: ...../...../.....	Signature: .....
	Provider No.: .....

Reason for Referral: (include history/physical findings)

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Provisional diagnosis: .....

Last seizure/event: Date: ...../...../..... Time: .....am/pm

Current Medications: .....

SEDATION REQUIRED  If yes, complete sedation order below

SLEEP DEPRIVATION  Discuss requirements at time of booking

<b>SEDATION ORDER:</b>	<b>AUTHORISED STAFF ONLY</b>
Recommend Vallergan Forte 3mg/kg.	
Patient's weight: ..... kg	Dosage given: ..... mg
Dose: ..... mg	Time given: .....
Signature: .....	Date given: .....
Date: .....	Signature: .....

**DO NOT WRITE ON THIS SIDE  
NEUROLOGY USE ONLY**

Date of test: .....	Previous EEG RCH:...../...../.....	Code No.: .....
Time of test: .....	Elsewhere:...../...../.....	EEG No.: .....

<b>Billing Status</b>	Recorded By: .....
<input type="checkbox"/> M/BB <input type="checkbox"/> Nk	Reporting Technologist: .....
<input type="checkbox"/> Z <input type="checkbox"/> TAC	Reporting Dr.: .....
<input type="checkbox"/> C <input type="checkbox"/> I	

Date and Time of last event: .....

Check Medication Given

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Conscious state: .....

Additional Information: (eg. nocturnal/febrile) .....

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**ICTAL RECORDING:** **TIME:** .....

Bookmark .....

Comments: .....

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