ELECTROPHYSIOLOGY REQUEST FORM

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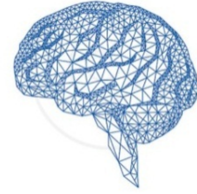

PATIENT INFORMATION – *affix patient label if applicable*

Last Name		**Address**	
First Name			
UR Number			
Date of Birth			
Contact Numbers			
Inpatient	**Y / N**	**Location**	
Interpreter	**Y / N**	**Language**	

REQUESTED STUDY *(please tick)*

EEG	Evoked Potential	Electrophysiology
☐ EEG	☐ Auditory	☐ Nerve Conduction
Specific requests:	☐ Visual	☐ Electromyography
	☐ Electroretinogram	
	☐ Electrooculogram	
	☐ Somatosensory	

CLINICAL DETAILS

(for urgent studies please contact on-call Neurologist via Department)

Question to be answered by study			
Behavioural difficulty	**Y / N** Please detail as this may impact the study performed		
Current Medications			
Pre-Surgical Study	**Y / N**	**Date of Surgery**	

REFERRING MEDICAL OFFICER DETAILS

Referring MO		**SIGNATURE**	
Provider Number			
Phone Number			
Fax Number		**Date**	
Consultant in charge of care			

NEUROLOGY DEPARTMENT USE ONLY							
Appointment Date						Triaged by and date	
Appointment Time							
TRIAGE DESIGNATION							
P1		P2		P3			
4 Weeks		6-8 Weeks		>8 Weeks			

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Women's & Children's Hospital