

NEUROPHYSIOLOGY DEPARTMENT REQUEST FORM



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PLEASE BRING THIS FORM WITH YOU WHEN YOU ATTEND HOSPITAL

All sections of this form must be fully completed

Room: _____	Date: _____	Surname <input type="text"/>
Appointment Date: _____	Time: _____	Forenames <input type="text"/>
Referring Consultant/GP: _____		Hospital no <input type="text"/> DoB <input type="text"/> Sex <input type="checkbox"/> M <input type="checkbox"/> F

DIAGNOSTIC TESTS	
Electroencephalography	Evoked Potential
<input type="checkbox"/> 551900 EEG - routine (hyperventilation & photic stimulation) **	<input type="checkbox"/> 551800 SEP upper OR lower
<input type="checkbox"/> 551910 EEG - sleep deprived **	<input type="checkbox"/> 551805 SEP upper AND lower
<input type="checkbox"/> 551988 EEG - prolonged (4 hours)	<input type="checkbox"/> 551630 BSER
<input type="checkbox"/> 551977 Portable EEG (inpatients only)	<input type="checkbox"/> 551740 VER - pattern (simple)
<input type="checkbox"/> 551926 Video telemetry (specify number of days _____)	<input type="checkbox"/> 551750 VER - pattern (full & hemi fields)
<input type="checkbox"/> 551090 Ambulatory EEG	<input type="checkbox"/> 551730 VER - flash
Home Electroencephalography	Electromyography
<input type="checkbox"/> 558007 Home video telemetry EEG	<input type="checkbox"/> 551930 EMG & nerve conduction studies
<input type="checkbox"/> 558009 Home video ambulatory EEG	<input type="checkbox"/> 551999 Nerve conduction studies only
<input type="checkbox"/> 558010 Home video telemetry with polygraphy	

** Please gain informed verbal consent prior to referral for sleep deprivation, photic stimulation and hyperventilation studies.

CLINICAL INFORMATION	
Provisional diagnosis:	
Medical history & clinical details:	
Medication:	
Doctor's name	
Doctor's signature	
Date	
Return of results	