TEST REQUIRED

☐ **Standard EEG** ☐ **Sleep Deprived EEG** ☐ **Overnight video-EEG and clinical review**
(see video-EEG check list form for eligibility)

PATIENT INFORMATION

Full name:

Address:

D.O.B: Age:

Tel: Mobile:

CLINICAL INFORMATION

Questions to be answered by the EEG:

Clinical information:

Description of seizure/event:

- Frequency of seizure/event:
- Date of the last seizure/event:
- Medication (Name/Dosage):

Previous EEG: Y / N Previous MRI/CT head result: Y / N

Report:

Location:

REFERRING DOCTOR'S DETAILS

Name: Provider No:

Address:

Tel: Fax:

Email:

Signature: Date: / /
