SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

iCare

DEMOGRAPHIC LABEL

ELECTROENCEPHALOGRAM – EEG REQUISTION

This requisition to be completed in full and signed by the physician. This information must be in the EEG Department before patient appointment is scheduled.

ORDERING PHYSICIAN: _____ COPIES TO BE SENT TO: _____

ORDER DATE: _____ TESTING DATE: _____ EEG# _____ TECH: _____

PLEASE CHECK ALL THAT APPLY:

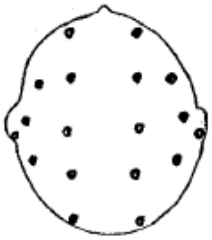
Sleep Deprivation: Yes ☐ No ☐ Omit Hyperventilation: Yes ☐ No ☐

Isolation Precautions: Contact ☐ Respiratory ☐

PATIENT ANALYSIS

Normal ☐ Confused ☐
Behaviour Difficulty ☐ Semi-comatose ☐
Aphasic ☐ Paralysis: Rt Arm ☐ Rt Leg ☐
Comatose ☐ Lt Arm ☐ Lt Leg ☐
Mentally Handicapped ☐

SKULL DEFECTS



Recent CVA ☐ Brain Surgery ☐ Intracranial Hemorrhage ☐

Other: _____

Medication: _____

_____

_____

(TO BE COMPLETED BY PHYSICIAN) CLINICAL INDICATION AND HISTORY:

_____

_____

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_____
SIGNATURE – REFERRING PHYSICIAN