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:

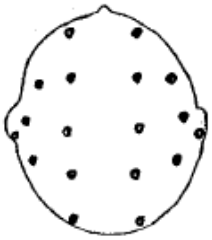
Sleep Deprivation: Yes ☐ No ☐ Omit Hyperventilation: Yes ☐ No ☐

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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Please fax to: 705-759-3714

_____

SIGNATURE – REFERRING PHYSICIAN