WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

EEG REQUISITION

Fax Requests to:
Phone: (519) 254-1727 Fax: (519) 255-2125

INCOMPLETE REQUESTS WILL BE RETURNED - Resulting in Delay or Cancellation of the Procedure

Patient Information (Please Print)

Name: _____ Date of Birth (MM/DD/YYYY):_____ Sex: ☐ M ☐ F

Address: _____ WSIB: _____ Patient's Weight: _____ lbs _____ Kgs

Primary Contact # ( ) _____ Secondary # ( ) _____ Patient's Height: _____ ft _____ in

Health Card #: _____ Version _____ Patient arriving from external healthcare facility: ☐ Y ☐ N

DOES THE PATIENT HAVE ANY SPECIAL REQUIREMENTS? IF YES, PLEASE INDICATE BELOW:

CLINICAL INDICATIONS / REASON FOR EXAM

- ☐ Seizure / Epilepsy
- ☐ Head Trauma
- ☐ Acute Confusional State
- ☐ Global Developmental Delay
- ☐ Dementia
- ☐ Sleep Deprived Recording
- ☐ OTHER: _____

LIST OF MEDICATIONS:

EEG PREPARATION:

1. Clean dry hair, no hairspray, gel or mousse.
2. Report to Diagnostic Imaging 15 minutes prior to appointment. Then go to EEG department on 8th floor.
3. May eat and drink (avoid caffeine).
4. Sleep Deprived Recording (only if indicated by referring physician)
   - ☐ Adults - awake at 2 a.m.
   - ☐ Children (2 - 7 years) - awake at 4 am
   - ☐ Infants < 2 years - awake 2 hours prior to appointment time

Print Referring Physician_____ Fax Number:_____

Referring Physician Signature:_____

Physicians who require copy of report:_____

APPOINTMENT:

DATE (MM/DD/YYYY):_____ TIME:_____ CAMPUS:_____