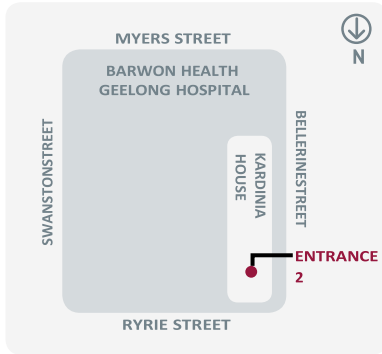


Please forward this form to the Neuroscience Department. An appointment letter will be sent directly to the patient.
All sections of this form must be fully completed.



Patient name _____

Address _____

Suburb _____ Post Code _____

DOB _____ Contact No. _____

Medicare No. _____ Work Cover TAC Overseas Visitor

INPATIENT UR: _____ URGENT NEXT AVAILABLE

<p>ELECTROENCEPHALOGRAPHY</p> <p><input type="radio"/> Routine EEG: Includes hyperventilation & photic</p> <p><input type="radio"/> Sleep deprived EEG <input type="radio"/> 3 hours <input type="radio"/> 8 hours</p> <p><input type="radio"/> Ambulatory EEG</p> <p><input type="radio"/> Video monitoring</p> <p>PAEDIATRIC ELECTROENCEPHALOGRAPHY</p> <p><input type="radio"/> Routine EEG: Includes hyperventilation & photic</p> <p><input type="radio"/> Sleep deprived: Includes hyperventilation & photic</p> <p>EVOKED POTENTIAL</p> <p><input type="radio"/> Visual Evoked Responses (VER)</p>	<p>ELECTROMYOGRAPHY</p> <p>Short</p> <p><input type="radio"/> Carpal tunnel</p> <p><input type="radio"/> Ulnar neuropathy</p> <p>Long</p> <p><input type="radio"/> Radial nerve</p> <p><input type="radio"/> Peripheral neuropathy</p> <p><input type="radio"/> Radiculopathy</p> <p style="padding-left: 20px;"><input type="radio"/> Cervical <input type="radio"/> Lumbar</p> <p><input type="radio"/> Motor neurone disease</p> <p><input type="radio"/> Polymyositis</p> <p><input type="radio"/> Other</p>
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MEDICAL HISTORY AND CLINICAL DETAILS – Must be completed

EEG Preparation: Clean and dry hair, no styling products
Nerve Conduction: Clean and dry hands/feet, no creams or oils, jewellery removed
VER: Please bring your glasses

Referring doctor / Supervising Consultant (if registrar referring) _____ Provider No. _____

Practice address / Department _____

Authorising signature _____ Date _____

INCOMPLETE REFERRALS WILL NOT BE ACTIONED