The Brainy Bunch Health Unit Trust
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EEG Request Form

Test requested:

☐ Standard EEG ☐ Sleep Deprived / Nap EEG

Paediatric neurologist consultation requested: Yes (If yes, please provide details below)

Patient Details:

Name: DOB:

Address:

Phone: Email:

History and Seizure Details:

Is there ASD level 2/3 or significant anxiety? No

Previous relevant investigations:

MRI:

EEG:

Medications:

Referring Doctor Details:

Name: Phone:

Clinic/ Address:

Provider number:

Signature: Date: