



EEG Requisition

We Accept Patients 6 years and Older

Name: _____ DOB (dd/mm/yyyy) _____

Address: _____ Sex: M F

_____ Health Card # & VC _____

Telephone (Home) _____

(Cell) _____



Patient Label

Please check off which test below:

- Routine
- Sleep-Deprived (SD)
- Ambulatory EEG
- Longer Recording (Please circle how long) 60 Min 120 Min 180 Min

Brief Clinical Info. _____

Medication _____

See Attached Medication List

Ordering Physician: _____ Billing #: _____

(Please Print)

Date: _____ Signature: _____

Report Copies To: _____

(Please Print)

PLEASE FAX REQUISITIONS TO 1-855-739-0003

Please note we need 24 hours notice of cancellation or you will be charged \$25.00.
Missed appointments will also be charged \$25.00.