Tele-N-Cephalon
Re-inventing health care delivery

# EEG Requisition

www.Neuro-Diagnostics.ca
Phone (437) 291-0456
**Fax 1-855-739-0003**

Name:_____DOB (dd/mm/yyyy)__ _____

Address:_____Sex: M ☐ F ☐

_____ Health Card # & VC_____

Telephone (Home)_____

(Cell)_____

Patient Label

**Please check off which test below:**

❑ **Routine** ☐ **In-Patient Hospital Name Floor ext. Number:**_____

❑ **Sleep-deprived (SD)**

❑ ***Ambulatory EEG ( 24 to 96 hours continuous EEG): Please attach the Consent form from https://www.neuro-diagnostics.ca/patient-area**

❑ **Longer Recording (Please circle how long) 60 Min 120 Min 180 Min**

Brief Clinical Info. _____

_____

_____

_____

Medication _____

**Ordering Physician:**_____**Billing #:** _____

(Please Print) **Fax # :**_____

Date:_____Signature:_____

Report Copies To:_____

(Please Print|)

7368 Yonge Street Unit 313, **Vaughan**
61 Dover Street **Chatham**
170 Colborne St W, **Orillia**
3030 Lawrence Ave East Unit 208, **Toronto**
2863 Ellesmere Road, Unit 406, **Scarborough**
52 Cannon Street Unit 103, **Hamilton**
300 Rossland Road E Unit 301**, Ajax**
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