HUMBER RIVER HOSPITAL

EEG Requisition

Neurodiagnostics Clinic

1235 Wilson Avenue (Keele & Wilson)

Portal of Care B, Level 1

Phone: 416-242-1000 ext. 47202

Fax: 416-242-1066

APPOINTMENT DATE: _____ **Time:** _____

Patients Name: _____ DOB: (d/m/yr) _____

HCN: _____ Version: _____

Address: _____ Postal Code: _____

Phone: (Home): _____ (Cell): _____

Examination Requested (please check one):

☐ Routine EEG ☐ Sleep-Deprived EEG ☐ Pediatric EEG

Reason for EEG: _____

_____

_____

Ref. Physician: _____ Billing Number: _____

Phone: _____ Fax: _____

Signature: _____ Additional Copy to: _____

****Please no caffeine the morning of examination****
Please ensure clean hair, no hair products, extensions or weaves
Thank you