BRISBANE NEUROLOGY

PRIVATE ELECTROENCEPHALOGRAM

EEG / EP

PATIENT REFERRAL FORM

PATIENT DETAILS

NAME: _____ DOB: _____

ADDRESS: _____

EMAIL: _____MOBILE: _____

MEDICARE NO: _____REF NO: _____

DVA (GOLD CARD ONLY):_____

TYPE OF EEG

- ☐ Routine (20-minute recording)
- ☐ Prolonged (60-minute recording)
- ☐ Sleep Deprived (60-minute recording)

TYPE OF EVOKED POTENTIALS (EP)

- ☐ Visual Evoked Potential (VEP)
- ☐ Somatosensory Evoked Potential (SSEP)

CLINICAL DETAILS

REFERRAL DETAILS

REFERRING DOCTOR NAME: _____

PROVIDER NUMBER:_____

SIGNATURE:_____DATE:_____

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