STRONG HEALTH

STRONG MEMORIAL HOSPITAL
Neurophysiology Lab
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EEG REQUISITION

SMH 405 MR

1 PATIENT INFORMATION

Patient Name: ______________________ D.O.B. __________

Patient Phone # ______________________ MRN: __________

Insurance Type: ______________________ Contract # __________

Please fill out this form completely and legibly

Office Use: Appointment Date: __________ Time: __________

2 Primary DIAGNOSIS

Brief description of problems, patient history, and questions to be addressed:

3 Current MEDICATIONS

4 Patient's CONDITION

❑ Cooperative ❑ Uncooperative

If uncooperative, may we use a papoose restraint for hook-up and if needed for the entire EEG?

❑ YES ❑ NO

5 Authorization for HYPERVENTILATION

❑ YES ❑ NO

(Relatively contraindicated: age > 70 years, pregnant, recent intra-cerebral hemorrhage, sickle cell disease, pulmonary disease, or heart disease)

6 EEG Requested (Our office will inform the patient where to report for their procedure)

❑ Outpatient EEG with video with sleep deprivation. (our standard test.)

A complete EEG requires that waking, drowsy and sleep states be recorded. Approximately 80% of patients are successfully recorded in all three states if they are sleep deprived. Sleep deprivation consists of less than 1/2 the normal sleep during the prior night.

❑ Outpatient EEG with video. No sleep deprivation. Please state reason why patient should not be sleep deprived: ______________________

❑ 24 hour Ambulatory EEG (no video). In most cases, at least one prior standard EEG should have been performed. 24 hour Ambulatory EEGs are most useful to record sleep in patients that did not sleep during a standard EEG or in patients that are having frequent spells that may be seizures.

❑ Same day inpatient EEG in ASC with anesthesiologist administering moderate sedation. (This option should be limited to uncooperative patients that cannot be restrained as the use of sedation may decrease the EEG yield.)

7 SIGNATURE

Physician or NP signature for EEG and restraint as indicated in above order:

Physician or NP name (Please print or stamp): ______________________

Phone Number or Pager Number: ______________________

Signature: ______________________ Date: __________

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