Nottingham University Hospitals **NHS**
NHS Trust

Clinical Neurophysiology Department
Request form for:

EEG SERVICES

Please indicate type of EEG required:

ROUTINE EEG, SLEEP DEPRIVED EEG, AMBULATORY EEG, VIDEO TELEMETRY, MSLT

Use adhesive label if available
Hospital No M / F
Surname Title
First name(s)
Address

Postcode DOB / /

Consultant ______________________
Speciality ______________________
Hospital ______________________
I/P Ward & Ext. ______________________

Provisional diagnosis

Reason for Referral (purpose of investigation)

History of Present Complaint

Previous Medical History

Relevant Family History
Findings (physical examination & other investigations, incl. EEGs and ambulatories)

Treatment (All medications, recent surgery etc.)

Urgency (if claiming priority over other patients, give reasons)

Mobility, Transport Arrangements &factors likely to affect ability to attend or cooperate:

FURTHER DETAILS, IF NOT GIVEN ABOVE

FOR EEG'S: Attack description

Age at Onset Frequency of attacks

Date of last attack Nocturnal Attacks Y / N Attacks on waking Y / N

Signature______________________________ Date______________
(referrals will not be accepted without a signature of a referring Clinician)

NB EEG referrals will **NOT** be accepted without an adequate history, if the referral is to exclude a diagnosis of epilepsy or for probable syncope without another reasonable cause)

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