

EEG REQUEST FORM

Patient Details

Name:

Date of Birth:

Address:

Contact Number:

Email:

Requesting Doctor Details

Name:

Practice Name:

Provider Number:

Contact Number:

Email:

 Specialist General Practitioner

*GP referrals accepted for adult EEG's only

EEG Testing

In-Clinic

 Routine Nap <3 years old Sleep Deprived Prolonged >3 hours

In-Home

 In-Home Video EEG Monitoring:

Number of nights (2-7): _____

 In-Home Ambulatory EEG (No Video): 1 night only

Preferred Clinic Location

 Norman Park Springwood Springfield Sunshine Coast Next Available

Reason for Referral

Past Medical History (including cerebrovascular, brain conditions, cardiac or pulmonary disease)

ASD Level 2/3 or significant anxiety

 Yes No

Current Medications

Previous Investigations (EEG, MRI)

Referral Disclosures

[Click here to access MBS Item 11000 \(routine\), 11003 \(prolonged daytime\), 11004 and 11005 \(ambulatory in-home\)](#)

 Does the indication for the EEG fulfill the relevant Medicare requirement listed above? Have you discussed the risks and benefits of **sleep deprivation** with the patient, if requested?

Signature: _____

Date: _____