

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 patients 16 years and over

EEG Testing

In-Clinic

☐ Routine

☐ Sleep Deprived

☐ Nap <3 years old

In-Home

☐ In-Home Video EEG Monitoring 2 nights

☐ In-Home Video EEG Monitoring 4 nights

☐ In-Home Video EEG Monitoring 6 nights

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

Preferred Clinic Location

☐ Springwood

☐ Springfield

☐ Sunshine Coast

☐ Toowoomba

☐ Townsville

☐ 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 \(in-clinic\), 11004 and 11005 \(in-home\)](#)

☐ 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: _____