07 3186 6997
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PRECISION EEG

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:** _____