Tele-N-Cephalon
Re-inventing health care delivery

EEG Requisition

www.Neuro-Diagnostics.ca
Phone (437) 291-0456
Fax 1-855-739-0003

Name:_____DOB (dd/mm/yyyy)__ _____

Address:_____Sex: M ☐ F ☐

_____ Health Card # & VC_____

Telephone (Home)_____

(Cell)_____

Patient Label

Please check off which test below:

- ❑ **Routine**
- ❑ **Sleep-deprived (SD)**
- ❑ **Ambulatory EEG (24 to 96 hours continuous EEG)**
- ❑ **Longer Recording (Please circle how long) 60 Min 120 Min 180 Min**

Brief Clinical Info. _____

_____

_____

_____

Medication _____

_____

☐ See Attached Medication List

Ordering Physician:_____**Billing #:** _____

(Please Print) **Fax # :**_____

Date:_____Signature:_____

Report Copies To:_____

(Please Print|)

7368 Yonge Street Unit 313, **Vaughan**

61 Dover Street **Chatham**

3030 Lawrence Ave East Unit 208, **Toronto**

2863 Ellesmere Road, Unit 406, **Scarborough**

550 Fennel Ave East Unit 208, **Hamilton**

300 Rossland Road E Unit 301**, Ajax**