Comprehensive Neurological Care Victoria

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EEG / NCS / EMG REQUEST FORM

REFERRING DOCTOR

Name:
Provider Number:
Address:
Phone:
Facsimile:

PATIENT DETAILS

Name:
Date of Birth:
Address:
Postcode:
Phone (Home): **(MOB):**

PLEASE TICK APPROPRIATE BOX BELOW FOR THE TEST REQUIRED:

EMG / NCS – Electromyography / Nerve Conduction Study

Simple:

☐ Carpal Tunnel Syndrome

Complex:

☐ Ulnar Neuropathy
☐ Peripheral Neuropathy
☐ Radiculopathy
☐ Radial Neuropathy
☐ Myopathy/Mysathenia Gravis
☐ Other

EEG - Electroencephalography

☐ Routine EEG (1 hour)
☐ Sleep Deprived EEG (1.5 hours)
☐ Prolonged Video EEG (3 hours)

CLINICAL DETAILS:

MEDICATIONS:		
Anticoagulation:	☐ **Yes**	☐ **No**
NEUROLOGICAL CONSULTATION NEEDED?	☐ **Yes**	☐ **No**
REFERRING DOCTOR'S SIGNATURE:	DATE:	

TO SCHEDULE AN APPOINTMENT PLEASE FAX REQUEST FORM TO (03) 9379 4115 *OR* PHONE: (03) 9379 4545

PATIENT INSTRUCTIONS (EEG): Wash your hair the night before or morning of your appointment. Hair should be dry and free of products including gels, hairspray, leave-in-condition, mousse etc. Do not drink tea, coffee or fizzy drinks before the appointment. (EMG/NCS): Shower and keep your skin clear from any fragrances, moisturisers and creams. Wear comfortable, loose fitting clothing to your appointment

Office Use Only**
Appointment Booked for: at: