EEG Diagnostics

NEUROWAVE

Neurowave Diagnostics Ltd.
Electro-Neurophysiology Clinic
EEG Services

Tel: 1 647-783-1975
Email: info@eegtest.ca
Fax No.: 1 647-372-5074

PATIENT INFORMATION

Name: _____

Date of Birth (MM/DD/YYYY): / /

Address: _____

_____

OHIP #: _____

Contact Number: _____

EEG Requisition

PLEASE SELECT ONE OF THE FOLLOWING TESTS:

☐ Routine	30 Minute Recording
☐ Prolonged Routine	60 Minute Recording
☐ Sleep Deprived	60 Minute Recording

Brief History and Clinical Information:

_____
_____
_____

Relevant / Anti-Seizure Medications:

_____
_____

☐ See Attached Medication List

Referring Physician: _____ **Signature :** _____

Address : _____

Phone: _____ **Fax:** _____

Billing #: _____

Date: _____ **Report Copies to:** _____

PLEASE FAX REQUISITIONS TO 1 647-372-5074