Alberta Health Services

Neurophysiology EEG/EP Requisition

Ensure request meets specific requirements where these are available.
For more information on criteria and where to send the request visit:
www.albertareferraldirectory.ca and search for "EEG"

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown		

Date *(dd-Mon-yyyy)*	Site *(for site locations visit www.albertareferraldirectory.ca and search for EEG)* choose one		
Patient Address		City	
Province	Postal Code	Primary Phone	Alternate Phone
Patient Type ☐ Adult ☐ Pediatric ☐ Neonatal *(for pediatric/neonatal patients, provide additional information below)* ▼			
Legal Guardian Name *(if applicable)*		Developmental Delay ☐ No ☐ Yes	
Ordering Physician Name	Phone	Fax	
Signature		Date *(dd-Mon-yyyy)*	

Request Information

Type of Request

☐ EEG
☐ Sleep Deprived EEG
☐ Other *(specify)* _____

☐ Evoked Potentials - ***available only at FMC and UAH*** *(specify type)* ▼
☐ Visual ☐ Auditory ☐ Somatosensory-upper ☐ Somatosensory-lower

☐ Neurologist **ONLY** order - Ambulatory EEG - ***available only at ACH and UAH*** *(specify type)* ▼
☐ 24 hours ☐ 48 hours ☐ V-AMB 24 hours

Reason for Referral

Diagnosis

Previous Testing ☐ No ☐ Yes *(if yes, provide details)* _____

Patient History *(include applicable signs and symptoms, previous investigations, brief description of events/seizures in question)*

Current Medications

Factors that may affect Consultation/Care

Interpreter required ☐ No ☐ Yes *(if yes, specify language)* _____

☐ Physical limitations ☐ Social/Psychological ☐ Other _____

Details _____

For Lab Use Only

EEG#	Interpreting Physician