Neuro NSW
Brain & Spine Specialists

Dr Sue Baumann - Neurologist

Electroencephalography (EEG) request form

Patient Name:	**D.O.B:**
Address: **Contact: Home:** **Mobile:**	

Test Type:	☐ **Routine EEG** ☐ **Sleep EEG**	☐ **Prolonged/ Ambulatory EEG *** (with Neurologist Approval)

Priority:	☐ **URGENT**	☐ **NON-URGENT**

Reason for Request/ Question:	
Please Tick –	☐ Clinical history suggestive of: • more than 1 unprovoked seizure that is epileptic in origin, or • 1 seizure with increased risk of subsequent seizures ☐ Question seizure type / epileptic syndrome ☐ Repeat EEG
Description of Attacks:	

Please attach reports for the following if available:

☐ **Previous Imaging**	☐ **Previous EEG**

Referring Doctor...

Provider No..

Signature.. **Date**..................................

Please email referral to: reception@neuronsw.com.au

PH: 02 66279406 Fax: 02 66279209 Mobile: 0450895050 (SMS, Voicemail)

If appointment is urgent please call clinic