



NHH

Northumberland
Hills Hospital

EEG Requisition

PH: (905) 372-6811 ext. 3050

N684

Affix Patient Label.

Please fax all EEG requisitions to (905) 373-6972

Please indicate ✓ Examination Requested:

EEG Requests

- Routine EEG
- Sleep Deprived EEG

Reason for Referral (required): _____

Duration of Symptoms (required): _____

Patient Instructions / Preparation

For all EEG Testing

- Wash and dry hair
- Please do not use hair conditioner, spray, oils, or gels.
- Hair braids and/or extension may need to be removed.

For Sleep Deprived EEG Testing

- Stay awake all night prior to EEG test.
- No beverages containing caffeine.
- Arrange driver to and from appointment.

Last Name: _____

First Name: _____

Address: _____

City: _____ Postal Code _____

Phone: (____) _____ - _____ D.O.B: _____

Health Card #:

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WSIB Claim #: _____ (HC version code)

NHH will contact patient directly with an appointment.

- Speak to Patient only Patient's consent to leave message.

Contact POA or other _____

Contact's Name: _____ Tele#: _____

Ordering Physician/Practitioner Data

Name:

OHIP Billing #:

CPSO #:

Ordering Physician's/Practitioner's Signature

Copies To:

(Include Address)