Brisbane Clinical Neuroscience Centre

Brain • Nerve • Spine

Private EEG Referral Form

Name: _____ Address: _____

DOB: _____ _____

Phone: _____ Email: _____

Medicare No: _____

EEG study requested

☐ Routine EEG (20-minute recording)

☐ Sleep deprived EEG (40-minute recording)

Clinical indication and reasoning for EEG:

☐ Confirm / evaluate for epileptiform activity

☐ Characterising the nature of a patient's seizure-like events

☐ Progress of known epilepsy/seizures

☐ Other, please specify _____

Clinical history and current medications:

_____

_____

_____

_____

_____

_____

Referral Details:

Name: _____ Provider number: _____

Clinic: _____ Phone: _____

Fax: _____ Email: _____

Date: _____ Signature: _____

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