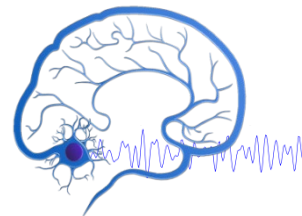


ELECTROPHYSIOLOGY REQUEST FORM

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Fax: (08) 8161 6246



PATIENT INFORMATION – *affix patient label if applicable*

Last Name		Postal Address	
First Name			
WCH UR Number			
Date of Birth and Gender			
Contact Number			
Inpatient	Y <input type="checkbox"/> N <input type="checkbox"/>	Ward and Bed Number <i>(for inpatients)</i>	
Interpreter	Y <input type="checkbox"/> N <input type="checkbox"/>	Language	

REQUESTED STUDY *(please tick)*

EEG	Evoked Potential
<input type="checkbox"/> EEG Specific requests:	<input type="checkbox"/> Visual <input type="checkbox"/> Electroretinogram <input type="checkbox"/> Electrooculogram

CLINICAL DETAILS *(for urgent studies, please contact the on-call Neurologist via the WCH hospital switchboard)*

Question to be answered by study			
Behavioural difficulty	Y <input type="checkbox"/> N <input type="checkbox"/>		
	<i>If yes, please detail as this may impact the study performed</i>		
Current Medications			
Pre-Surgical Study	Y <input type="checkbox"/> N <input type="checkbox"/>	Date of Surgery	

REFERRING MEDICAL OFFICER DETAILS – *all details must be completed*

Name		SIGNATURE	
Provider Number			
Practice Name			
Phone Number			
Fax Number		Date	
Consultant in charge of care <i>(if applicable)</i>			

NEUROLOGY DEPARTMENT USE ONLY

TRIAGE DESIGNATION			Sign and Date	 Government of South Australia SA Health	 Women's & Children's Hospital
P1	P2	P3			