EEG-EMG-NCS REQUISITION FORM

2950 Eglinton Ave E, Scarborough, ON M1J 2E7

F:(416)-438-3633

PATIENT INFORMATION:

Name: _____

Date of Birth : _____ **M** ☐ **F** ☐

Address: _____

OHIP: _____

Contact Number: _____

PHYSICIAN INFORMATION:

Name: Dr. _____

Address: _____

Phone: _____ **Fax :** _____

Billing: _____ **Date:** _____

Signature: _____

Routine Electroencephalography Adult (EEG) & PEDIATRIC (EEG)

Clinical Indication (Please Specify)

☐ Epilepsy/Seizures	☐ Staring Spells
☐ Fainting (Syncope)	☐ Hallucination
☐ Headache/Migraines	☐ Sleep Disorders
☐ Motor Vehicle Accidents/Head Injury	☐ Brain Tumors
☐ Stroke/TIA	☐ ASD Assessment
☐ Encephalopathy	☐ Memory Issues
☐ Dementia/ Alzheimer's	☐ Other (Specify)

☐ Routine EEG	☐ 60 min	
☐ If Routine EEG Normal Sleep Deprived	☐ 60 min	
☐ Prolonged EEG (Please tick appropriate)	☐ 120 min	☐ 180 min

Electromyography (EMG) / Nerve Conduction Studies (NCS)

Clinical Indication (Please Specify)

☐ Carpel Tunnel Syndrome	☐ Peripheral Neuropathy
☐ Ulnar Neuropathy	☐ Myopathy
☐ Cervical Radiculopathy	☐ Other (Specify)
☐ Lumbar Radiculopathy	

Additional Comments/History: _____

Relevant Medications: _____