	(Affix identification label here)
Queensland Government	URN:
<del>Chia sabilis</del>	Family name:
EEG Paguast Form	Given names:
EEG Request Form	Address:
Facility: TOOWOOMBA HOSPITAL	Date of birth: Sex: M F I
☐ Outpatient  Send to: Referral Centre ☐ Inpatient  Fax to: 07-4688 6088  Form must be comp for test to be perfor lincomplete form will be returned.	rmed. (Include current medication and doses)
► Ward:	Antipsychotic:
► Bed:	Antipsycholic.
	Paralysing / Sedative agents:
Contact person:	Faralysing / Secalive agents.
	Other:
Urgent Not urgent	Ottlef.
Routine Sleep Deprived  Long term video EEG	
Clinical question to be answered by EEG	ECT?
	Yes
	□ No
	Details:
	Recent lumbar puncture?
	Yes
	No
	Intellectual / physical disabilities which may affect ability to comply with test?
Clinical details (include type of epilepsy, previous brain i	insult Yes
side of lesion, drugs, alcohol and previous medical history)	No
	Details:
	Infectious / contact precautions:
	Yes
	□No
	LMO (GP):
	Medical Centre:
	Requested by:
	Designation:
Date of last episode: / / /	Signature:  Consultant initial/last name:
PATIENT TO SIGN:	
I have been informed that this procedure will be	Date: / /
videoed for clinical purposes and agree to this be	ing OFFICE USE ONLY:
undertaken.	Date of test: / /
Patient signature	Time of test: :



」verbal consent obtained

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Test reference no: