



NEURO ELECTRODIAGNOSTICS SERVICES INPATIENT REQUISITION

For In-Patient Bookings – South Island

RJH Phone 250-370-8247 VGH Phone 250-727-4200 Fax 250-370-8070 Fax 250-727-4368

SURNAME GIVEN NAME(S) GENDER PHN / MRN DOB AGE Hospital Unit Room #/bed Local

TEST SITE (please check): RJH [ ] VGH [ ]

[ ] EEG (Electroencephalogram) Patient should have clean dry hair, no hair products.

[ ] Sleep Deprived EEG Please contact the EDS-Neurology Department for sleep deprivation instructions.

[ ] 24-Hour Ambulatory EEG Set Up 2 hours, removal 1/2 hour the following day \*Must be ordered by a Neurologist \*Must have had recent prior routine EEG. Monitor and diary are sent back to the ward with patient, who must return the next day for removal.

Evoked Potentials - RJH only (may only be ordered by a Specialist)

[ ] VER (Visual) Visual Acuity OD \_\_\_\_\_ OS \_\_\_\_\_

[ ] SEP (Somatosensory) [ ] Upper [ ] Lower

[ ] BAER (Brainstem Auditory) Threshold R \_\_\_\_\_ L \_\_\_\_\_

EMG (Electromyogram) / NCV (Nerve Conduction Study) DO NOT ORDER HERE. Please arrange directly with a Neurologist or Physiatrist.

Escort Required? [ ] Security [ ] Nurse Mode of Transport [ ] Wheelchair [ ] Stretcher [ ] Bed [ ] Ambulatory Precautions [ ] Contact [ ] Droplet [ ] Violence risk [ ] Airborne Is the Patient [ ] On Dialysis? Provide Schedule [ ] Receiving ECT? Provide Schedule [ ] Query Prion disease [ ] Scalp lesion/burn/drain? [ ] On CNS altering Drugs? Specify

Requisition Date: \_\_\_\_\_ Date Required: \_\_\_\_\_ [ ] Urgent [ ] Semi-Urgent [ ] ASAP [ ] Routine [ ] System Utilization

Provisional Diagnosis (History, Reason for Test): \_\_\_\_\_

Medication(s): \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

PHYSICAL OR MENTAL CHALLENGES – PATIENTS WITH PHYSICAL OR MENTAL CHALLENGES MAY REQUIRE MORE TIME FOR TESTING.

PLEASE SPECIFY: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_

Requested Interpreting Physician: \_\_\_\_\_

CC: \_\_\_\_\_