island health

NEURO ELECTRODIAGNOSTICS SERVICES
OUTPATIENT REQUISITION

For Out-Patient Bookings at RJH/VGH/NRGH

Phone 250-370-8333 Fax 250-370-8170

SURNAME, GIVEN NAME(S) GENDER

PHN / MRN

DOB AGE

ADDRESS

TELEPHONE CELL

TEST SITE (please check): RJH ☐ VGH ☐ NRGH ☐ First Available Site ☐

☐ **EEG (Electroencephalogram)** 1 – 1 ½ hours.
Arrive with clean dry hair, no hair products.

☐ **Sleep Deprived EEG** 1 ½ hours
Sleep deprived EEGs require 4 hours less sleep than usual the night before. If needed, Chloral Hydrate may be prescribed by the ordering Physician and brought to the hospital by the patient. Arrive with clean dry hair, no hair products. No caffeine prior to testing.
*Sleep deprived or sedated patients must have a driver to and from the hospital.

☐ **Pediatric Daycare/Short Stay EEG** (VGH and NRGH)

☐ **24 Hour Ambulatory EEG**
Set Up 1 ½ - 2 hours, removal ½ hour the following day
*Must be ordered by a **Neurologist**
*Must have had **prior routine or sleep EEG**
Arrive with clean dry hair, no hair products. Wear button or zip up shirt. Bring hat. Monitor is sent home with the patient who must return the next day for removal.

☐ **VNG/ENG (Videonystagmogram)** (RJH only)
Anti -dizzy drugs, antihistamines, sleeping pills, sedatives, tranquilizers and codeine may need to be discontinued 48 hours prior to testing (at discretion of physician). No eye liner or mascara. Driver home recommended, as patients may experience dizziness. Test Time 1–1 ½ hours
☐ **VEMP** (Vestibular Evoked Myogenic Potentials)
Test time 30 minutes

Evoked Potentials (RJH and NRGH only)
☐ **VER (Visual)** Visual Acuity OD _____ OS _____
Bring glasses or contact lenses. Test Time 45 minutes.
☐ **SEP (Somatosensory)** ☐ **Upper** ☐ **Lower**
Wear loose comfortable clothing. Test Time 45 minutes
☐ **BAER (Brainstem Auditory)** Threshold R ____ L ____
Test Time 45 minute

☐ Urgent ☐ Semi-Urgent ☐ ASAP

Requisition Date:_____ Date Required: _____ ☐ Routine ☐ Timed

Provisional Diagnosis (History, Reason for Test):

_____

_____

Medication(s): _____

Height: _____ Weight: _____ Allergies:_____

☐ **SPECIAL PRECAUTIONS**: _____

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

PLEASE SPECIFY: _____

Ordering Physician:_____ Requested Interpreting Physician: _____

CC: _____

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