CHILDREN'S HEALTH

PHYO
CMC 38380-008NS Rev. 7/2012

Neurophysiology Laboratory Requisition
Electroencephalogram (EEG) and Evoked Potential (VEP, SSEP, BAEP)

MED REC NO._____ ACCT NO._____
PATIENT_____
DATE _____ LOCATION _____
DOB_____

	Name	Phone #	Fax #
Referring provider information			
Primary care physician			

Type of study requested:

- ☐ Awake and asleep Electroencephalogram (EEG) (with sleep deprivation)
- ☐ Awake Electroencephalogram (EEG)
- ☐ _____ Hour outpatient EEG monitoring with Video
- ☐ 24 hour outpatient ambulatory EEG monitoring without video
- ☐ 48 hour outpatient ambulatory EEG monitoring without video
- ☐ 72 hour outpatient ambulatory EEG monitoring without video
- ☐ Brainstem Auditory Evoked Potential (BAEP)
- ☐ Somatosensory Evoked Potential (SSEP)
- ☐ Visual Evoked Potential (VEP)

For all evoked potential orders:

Please note known sensory or motor deficits:

_____

What do you want to learn from this study?

- ☐ Seizures / Possible seizures
  - ☐ *Febrile*
  - ☐ *Absence*
  - ☐ *Generalized*
  - ☐ *Partial*
  - ☐ *Infantile spasms*
  - ☐ *Other (specify):*
- ☐ Other _____
- ☐ Compare w / prior CMC EEG: (date) _____
- ☐ Possible focal brain disorder: (specify) _____
- ☐ Screen for any brain disorder: (specify) _____

For all studies:
Please specify the question you would like answered:

Diagnoses: _____
(Please give diagnosis code(s)
_____
_____

Medications patient is taking: _____
_____
_____

I have discussed the indications for the procedure with the patient's parents or legal guardian.

Referring Provider signature and credentials: *(required)* **(Circle one): MD DO APN PA AA CRNS RN**	**Date:** **Time:**
Print Provider name:	**Office contact person:**

CMCD Neurophysiology Fax #- 214-456-7305