Routine Electroencephalogram (EEG) Referral Form

Referral forms only accepted from non eReferral users

Please download and save a local copy of this form prior to completing. We recommend opening the form in Abode Reader.

Patient Demographic Information

First Name: _____ Surname: _____

Date of Birth: _____ Gender: _____

Address: _____

_____

Next of Kin: _____ Telephone: _____

Patient Clinical Information

Relevant Clinical History:	
Significant Comorbidities:	
Family History of Epilepsy? *If yes, who?*	
Gestational Age: *(for infants)*	
Date of Last Seizure/Event:	

Precipitating Causes?	
Events:	☐Awake ☐Asleep
Frequency of Events:	
Infection control risk? *If yes, please specify?*	☐Yes ☐No
Mobility:	☐Ambulant ☐Wheelchair
Current Medications	
Follow up arranged?	☐Yes ☐No
Name of Requesting Consultant	
Requested timeframe	☐ASAP ☐Clinically Urgent

Referrer Information

Name: _____ Provider Number: _____

Agency: _____ Telephone: _____

Address: _____

_____

Signature: _____ Date: _____

Please submit this form directly to PCH Neurophysiology by clicking below or email directly

Submit form to PCH Neurophysiology

Email PCH.NeurophysiologyReferrals@health.wa.gov.au
For any queries, please call Neurophysiology – (08) 6456 4333