North Bay Regional Health Centre

Cardiorespiratory Services
Electroencephalograph Requisition

For Appointments please call: 705-474-8600 Ext 4531
Fax # 705-495-8116

Date of Test**:**	Time:	Age:
Referring physician:	Sleep Deprived: EEG ☐ Yes ☐ No	

SEIZURE HISTORY

A) Description:
B) Precipitating causes:
C) Family History:
D) Age on onset:
E) Frequency:
F) Time:
G) Date of last episode:
H) General condition of patient:
I) History, physical findings:
J) List all medications taken in the past three weeks:

Date: _____ Physician Signature: _____

Physician Print Name: _____