The Royal **Children's** Hospital Melbourne

# EEG Referral

## Patient details *(We require all fields of the patient details to be completed clearly)*

Patient surname: Given name:

Date of birth: RCH UR number *(if known)*:

Gender:

Address: Postcode:

Mobile number:

Medicare number: Ref number: Expiry date:

Non Medicare eligible

Indigenous status: Aboriginal Torres Straight Islander Not indigenous

Interpreter: Yes No Language:

## Referring doctor details *(Please complete clearly)*

Given name: Surname:

Provider number:

Practice name:

Practice address:

Telephone number: Fax number:

Doctor's signature: Date:

## Clinical details

Clinical history:

Specific issue/question to be addressed:

Sleep deprivation required: Yes No

Last seizure: <20 minutes <1 hour <1 day <1 week >1 month Unknown Not applicable

Event occurrence: Awake Asleep Awake & asleep Unknown Not applicable

Provoking factors *(optional)*:

Comorbidities *(optional)*: Learning/Attention difficulties Intellectual disability Regression Autism Cerebral palsy Behavioural difficulties ADHD Other:

CC results to *(name, address, provider number)*:

Medications *(if none write none)*:

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