NEURO ELECTRODIAGNOSTICS SERVICES INPATIENT REQUISITION

For In-Patient Bookings – South Island

RJH Phone 250-370-8247
Fax 250-370-8070

VGH Phone 250-727-4200
Fax 250-727-4368

SURNAME GIVEN NAME(S) GENDER

PHN / MRN

DOB AGE

Hospital Unit Room #/bed x Local

TEST SITE (please check): RJH ☐ VGH ☐

☐ **EEG (Electroencephalogram)**
Patient should have clean dry hair, no hair products.

☐ **Sleep Deprived EEG**
Please contact the EDS-Neurology Department for sleep deprivation instructions.

☐ **24-Hour Ambulatory EEG**
Set Up 2 hours, removal ½ hour the following day
*Must be ordered by a **Neurologist**
*Must have had **recent prior routine EEG**.
Monitor and diary are sent back to the ward with patient, who must return the next day for removal.

Evoked Potentials - RJH only
(may only be ordered by a Specialist)
☐ **VER (Visual)** Visual Acuity OD _____ OS _____
☐ **SEP (Somatosensory)** ☐ **Upper** ☐ **Lower**
☐ **BAER (Brainstem Auditory)** Threshold R _____ L _____

EMG (Electromyogram) / NCV (Nerve Conduction Study) DO NOT ORDER HERE. Please arrange directly with a Neurologist or Physiatrist.

Escort Required? ☐ Security ☐ Nurse

Mode of Transport ☐ Wheelchair ☐ Stretcher ☐ Bed ☐ Ambulatory

Precautions ☐ Contact ☐ Droplet ☐ Violence risk ☐ Airborne

Is the Patient
☐ On Dialysis? Provide Schedule
☐ Receiving ECT? Provide Schedule
☐ Query Prion disease
☐ Scalp lesion/burn/drain?
☐ On CNS altering Drugs? Specify

_____

_____

Requisition Date:_____ Date Required: _____ ☐ Urgent ☐ Semi-Urgent ☐ ASAP ☐ Routine ☐ System Utilization

Provisional Diagnosis (History, Reason for Test):

_____

_____

Medication(s): _____

Height: _____ Weight: _____ Allergies:_____

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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