Children's Health Queensland
Hospital and Health Service

Request for Paediatric EEG

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

NOT A REFERRAL FOR CLINICAL CARE

☐ EEG transfer for read only (EEG acquisition by non-QCH scientists) ▸ originating HHS for EEG:

CAUTION: Will this EEG help with clinical care?
Check this test is indicated: When an EEG does not add value for healthcare

TEST REQUESTED:

CLINICAL INFORMATION (mandatory for EEG triage and report quality)

Clinical details (include any relevant epilepsy aetiology)

☐ Patient has ASD Level 2/3, behaviour or anxiety disorder

Question to be answered by EEG:	**Medications:**

Seizure/event description:

Frequency:	**Last seizure:**

Previous investigations (EEG/MRI) and results:

Ongoing Specialist Care Provider (all fields mandatory, including details for distribution of report, or form will be returned)

Specialist Care Provider ▸ Given name: **Surname:**

Hospital or Private Practice name:

Consultant phone:	**Date:**

Method for report:

Requesting Doctor (if different from above, report will be distributed only to the Ongoing Specialist Care Provider)

Name:	**Phone:**

Email:

- **Complete all required fields before submitting (all fields will be locked on submission)**
- **Ensure your default email application is open before submitting**
- **Use SUBMIT function only (do not print for scanning or faxing)**
- **If form locks, close (without saving) and start again**

DO NOT WRITE IN THIS BINDING MARGIN

REQUEST FOR PAEDIATRIC EEG