SOUTHERN ONTARIO EPILEPSY CLINIC
IMPROVING CARE THROUGH EDUCATION

Electroencephalogram (EEG) Requisition

Thank you for choosing Southern Ontario Epilepsy Clinic for your EEG needs . To best serve you within a reasonable time frame please have this form filled out completely and legibly so that it can be appropriately triaged by. Dr. Bercovici.

PLEASE FAX COMPLETED REFERRAL FORM TO **416-620-7633**

Patient Information

Name: _____ DOB: _____

Health card number: _____ Version Code: _____

Address: _____ City: _____

Telephone #: Mobile: (_____)_____ Home/Business: (_____)_____

Type for EEG (done with time locked video)

( ) Routine ( ) Sleep Deprived

( ) Prolonged video (Circle either 2 3 hour) ( ) 24 hour Ambulatory

Priority: ( ) Next available ( ) ASAP (please state reason) _____

Clinical history: _____

Medications: _____

Previous surgery:_____

Allergies: _____

Referring Physician information

Name: _____ (MD / NP) Billing # _____

Address: _____

Telephone # _____ Fax # _____

Signature: _____

Southern Ontario Epilepsy Clinic : 308-190 Sherway Drive, Toronto, ON, M9C-5N2
Tel: 416-620-SOEC (7632) FAX: 416-620-7633