



# WRHN

Waterloo Regional  
Health Network

## EEG TESTING CLINIC

### Outpatient Requisition

Please complete ALL sections Incomplete requisitions  
will be returned

| Waterloo Regional Health Network<br>EEG Services<br>Phone: 519-749-4300 x 4603 Fax: 519-749-4241   |                       |  |   |
|--|-----------------------|--|---|
| Patient's Last Name:   | Patient's First Name: | Initial:   | <input type="checkbox"/> Male <input type="checkbox"/> Female<br><input type="checkbox"/> Other _____ |
| DOB (year/month/day):  | Health Card #:        | Version Code:  | WSIB Claim #:   |
| Street Address:  | City:                 | Province:  | Postal Code:  |
| Patient's Phone:   | Cell Phone:           | The patient consents to messages being left at this number <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| <b>Services Requested:</b>   |                       |  |   |
| <input type="checkbox"/> Regular Electroencephalogram (EEG)  |                       | <input type="checkbox"/> Sleep Deprived Electroencephalogram (SDEEG)   |   |
| <b>Clinical Diagnosis (this area MUST be completed, or requisition will be returned)</b>   |                       |  |   |
| <br><br><br><br>   |                       |  |   |
| <b>Additional Information</b>  |                       |  |   |
| <b>Pediatric Referrals</b>   |                       | <b>Adult Referrals</b>   |   |
| <input type="checkbox"/> Is the patient expected to be experiencing absence seizures?<br><input type="checkbox"/> Is the patient under 2 (high risk for epileptic encephalopathy)?<br><input type="checkbox"/> Is the patient experiencing infantile spasms? |                       | <input type="checkbox"/> Will this test help to determine treatment?<br><input type="checkbox"/> Is this patient suspected to be having frequent seizures? |   |
| Additional Comments:   |                       |  |   |
| <b><i>To ensure the most appropriate intervention, please include relevant operative reports, consult notes, imaging results, and rehabilitation therapy reports (unless available through Clinical Connect).</i></b>  |                       |  |   |
| Referring Physician Name (please print):   |                       | Physician's Phone #:   | Physician's Fax #:  |
| Family Physician:  |                       | Copies to Dr.:   |   |
| Physician's Signature:   |                       | Physician's Billing #:<br>(Required)   |   |

## Information for Patients

Appointment Date: \_\_\_\_\_

Appointment Time: \_\_\_\_\_

Appointment Location:

☐ **WRHN @ Midtown**

Waterloo Regional Health Network  
**835 King Street West**  
**CRES - Unit 3 E, Main Hospital**  
Kitchener, Ontario  
N2G 1G3

☐ **WRHN @ 40 Green**

Waterloo Regional Health Network  
**40 Green Street**  
**EEG Services – 5<sup>th</sup> Floor – 40 Green Street**  
Kitchener, Ontario  
N2G 4K9

Comments:

## Reminders

- **Notify EEG Services to rebook or cancel appointments – (519) 749-4300 x 4603**
- Arrive 15 minutes early to get registered – Test will be rebooked if you are late
- Bring your health card

## Preparing for your test

- Exam takes about one hour.
- You must have clean, dry hair. NO grease, oil, mousse, spray, or gel.
- If you are scheduled for a sleep deprived EEG, the most important preparation for this test is to ensure your sleep schedule is upset by waking at midnight. For younger children who nap, schedule test for nap time.

*Note: Referrals accepted only for patients residing within Waterloo-Wellington*