SUNY DOWNSTATE Medical Center

NAME:

MR #

N.S.

Service/Doctor

Phone Number: (718) 270-2959 **Fax Number: (718) 270-4711**

REQUEST FOR ELECTROENCEPHALOGRAM

Date of request: _____

Requesting Attending MD: _____

Requesting Resident / Fellow: _____

☐ Outpatient ☐ Inpatient / Admission Date: _____

Location (specify clinic, ward or nursing station): _____

Previous EEG at SUNY DMC: ☐ No ☐ Yes Year: _____

Type of EEG requested:

☐ Wake and Sleep ☐ Wake only ☐ Sleep only

☐ Prolonged 40 – 60 min ☐ Prolonged > 1 hr ☐ Sedated

Diagnosis: _____

Medications: _____

Pertinent History:

Patient instructions: Wash your hair the night before your appointment. Hair should be dry and free of products including gels, sprays, mousse, etc. Do not drink coffee, tea or cola before the appointment.