Children's Hospital of Eastern Ontario
Centre hospitalier pour enfants de l'est de l'Ontario
401 Smyth Road, Ottawa, ON K1H 8L1, Canada
(613) 737-7600 www.cheo.on.ca

NEUROPHYSIOLOGY REQUISITION

Fax: 613-738-4879

UNIT/WARD INFO

SURNAME	GIVEN NAME & INITIALS
WARD OR DEPT.	DATE OF BIRTH
STREET ADDRESS	TELEPHONE
CITY & PROVINCE	OHIP NO. & SUBSCRIB. INITIALS
TELEPHONE (H)	TELEPHONE (B)

(Please print or use sticky patient label with ward/unit info)

RESULTS TO BE SENT TO : (Mandatory information with address)

Reason(s) for Referral:

SIGNATURE

Current medication(s):

Date: | **Referring Physician (PLEASE PRINT):**

EEG(Electroencephalography):

☐ Routine EEG ☐ Sleep deprived EEG ☐ Ambulatory EEG Duration_____ hrs / days ☐ Prolonged Video EEG, Duration_____ hrs / days

☐ Other instructions (please specify):_____

☆ **Indicate if testing is scheduled in conjunction with MRI under GA: Yes{ } No{ }**

EVOKED POTENTIAL (EP) STUDIES:

☐ BAEP (Brainstem EP) ☐ VEP (Visual EP) ☐ Upper limb SSEP(Somatosensory) ☐ Lower limb SSEP (Somatosensory) ☐ MEP-Mag Stim (Motor EP).

☐ Other evoked potentials (please specify):

☐ NCS (Nerve conduction study) ☐ EMG (Electromyography) ☐ Transmission studies

☐ Nerves to be studied: _____

INTRAOPERATIVE MONITORING : **Please indicate details of surgical procedure to help plan monitoring modality in advance**

☐ Lower limbs SSEP ☐ Upper limbs SSEP ☐ BAEP ☐ NCS/EMG ☐ MEP ☐ ECOG (Electrocorticography)

Please specify level and type of surgery_____

FOR OFFICE USE ONLY:

Date and time received: _____ Appointment . scheduled: _____

Notes:_____