Royal Hospital for Children and Young People
Paediatric Clinical Neurophysiology Department

Direct Line: 0131 312 1506/EXT 51506
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CYP EEG Request Form

Name:

DOB:

Unit No./CHI:

Investigation Required:

Routine EEG ☐ Any specific request:

Sleep EEG ☐ Sleep Deprived ☐ Natural ☐ Melatonin / Other ☐ _____

Ambulatory EEG, Videotelemetry and Home Videotelemetry must be discussed with the Paediatric Neurology Consultant prior to request. Please select test and duration required.

Video telemetry ☐

Home Video telemetry ☐ 24Hr ☐ 48Hr ☐ Other ☐

Ambulatory ☐

Why do you want an EEG / this investigation? _____

If this request is urgent, have you discussed this with the Paediatric Neurology Consultant prior to request? _____

_____

Relevant Past Medical History: (Including: developmental history, learning difficulties, behavioural problems)

Relevant Examination and imaging findings: _____

Medication: _____

_____

Referring Consultant:

Signed:

Print:

Date:

Referring Hosptial:

Inpatient/Outpatient:

Ward/Department:

S0Number: