Mater Private EEG Service

Patient referral form

Date / /

Referring doctor

From

Test required

- ☐ Routine EEG
- ☐ Sleep Deprived EEG
- ☐ Prolonged EEG (3 hours)
- ☐ Prolonged/Sleep Deprived EEG (3 hours)

Patient details

Name DOB / /

Address

Telephone b/h

Telephone a/h

Email

Private Health Insurance Yes / No

Indication

- ☐ Confirm/exclude epileptiform activity
- ☐ Define the nature of seizure-like event
- ☐ Progress of known epilepsy/seizures
- ☐ Other, please specify:

Clinical details

Signature:

Our expert team of specially trained health professionals are now taking referrals for the Mater Private EEG Service.

Telephone: 07 3163 8333 **Fax**: 07 3163 3601
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