CortX Diagnostics

EEG REQUEST FORM

Barbados: Delaware Neurology, Delaware Building, St. Michael | (246) 235-5457
Saint Lucia: Serenity Therapeutic Centre, Chausee Rd, Castries | (758) 715-7825
Please bring this completed form to your EEG appointment.

Patient's Name		DOB	Age
Address			
Tel (H) Tel (W) Tel (C)	Gender Male ◯ Female ◯	Handedness: Right ◯ Left ◯	
Referral Type **Out-Patient EEG** ◯ **In-patient EEG** ◯ **Location:**			
Request Type: Routine EEG ◯ Sleep Deprived EEG ◯ 24HR Ambulatory EEG ◯			
Date of Request	Requesting Doctor	Email (For report)	
Abstract History (Include description of Seizure activity)			
Neurological Findings			
Provisional Neurological Diagnosis			
What question would you like answered?			
Routine Medication		Signature	

ATTENTION:

PATIENT INSTRUCTIONS TO FOLLOW

- **Go to bed later than usual and wake up early. (No more than 5hrs of sleep)**
- **All children must be accompanied by an adult**
- **Cell phones must be off during the test**
- **No fasting is required. Take your medication as prescribed.**
- **Hair Must be washed and free from grease or gel and in singles.**