NEUROPHYSIOLOGY DEPARTMENT REQUEST FORM

Bupa CROMWELL HOSPITAL

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PLEASE BRING THIS FORM WITH YOU WHEN YOU ATTEND HOSPITAL
All sections of this form must be fully completed

Room: Date:

Appointment Date: Time:

Referring Consultant/GP:

Surname

Forenames

Hospital no DoB Sex M F

DIAGNOSTIC TESTS

Electroencephalography

- ☐ 551900 EEG - routine (hyperventilation & photic stimulation) **
- ☐ 551910 EEG - sleep deprived **
- ☐ 551988 EEG - prolonged (4 hours)
- ☐ 551977 Portable EEG (inpatients only)
- ☐ 551926 Video telemetry (specify number of days _____)
- ☐ 551090 Ambulatory EEG

Home Electroencephalography

- ☐ 558007 Home video telemetry EEG
- ☐ 558009 Home video ambulatory EEG
- ☐ 558010 Home video telemetry with polygraphy

Evoked Potential

- ☐ 551800 SEP upper OR lower
- ☐ 551805 SEP upper AND lower
- ☐ 551630 BSER
- ☐ 551740 VER - pattern (simple)
- ☐ 551750 VER - pattern (full & hemi fields)
- ☐ 551730 VER - flash

Electromyography

- ☐ 551930 EMG & nerve conduction studies
- ☐ 551999 Nerve conduction studies only

** Please gain informed verbal consent prior to referral for sleep deprivation, photic stimulation and hyperventilation studies.

CLINICAL INFORMATION

Provisional diagnosis:

Medical history & clinical details:

Medication:

Doctor's name	
Doctor's signature	
Date	
Return of results	